HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
JULY 24, 2013
APPLICATION SUMMARY

NAME OF PROJECT:	Summit Medical Center
PROJECT NUMBER:	CN1304-011
ADDRESS:	5655 Frist Boulevard Hermitage (Davidson County), TN 37076
LEGAL OWNER:	HCA Health Services of Tennessee, Inc. 5655 Frist Boulevard Hermitage (Davidson County), TN 37076
OPERATING ENTITY:	NA
CONTACT PERSON:	John Wellborn (615) 665-2022
DATE FILED:	April 11, 2013
PROJECT COST:	$4,933,576.00
FINANCING:	Cash Reserves of the parent corporation, HCA
REASON FOR FILING:	1) Initiation of Inpatient Rehabilitation Services 2) Conversion of twelve (12) Adult Psychiatric beds to twelve (12) Rehabilitation beds 3) Conversion of eight (8) Adult Psychiatric beds to eight (8) Medical/Surgical beds

DESCRIPTION:

Summit Medical Center (SMC) is seeking approval for initiation of inpatient rehabilitation services and conversion of twelve (12) adult psychiatric beds to twelve (12) rehabilitation beds and the conversion of eight (8) adult psychiatric beds to eight (8) medical/surgical beds. The proposed conversion will not change the hospital's total licensed bed complement of one hundred and eighty-eight (188) acute care beds. The applicant states that if the proposed project is

approved, Skyline Medical Center will delicense its ten (10) remaining rehabilitation beds at its Madison campus (in northern Davidson County).

The applicant states that SMC's psychiatric inpatients can be absorbed by Skyline-Madison's adult psychiatric program.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

COMPREHENSIVE INPATIENT REHABILITATION SERVICES

1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.

See criterion #2 below.

2. The need shall be based upon the current year's population and projected four years forward.

County	*Davidson*	*Wilson*	*Service Area*
2017 Rehab Bed Need	*68*	*13*	*81*
Current Certified Rehab Beds	*202*	*26*	*228*
Net Need/ -Surplus (Based on Certified Beds	*-134*	*-13*	*-147*

The chart above indicates there is a net surplus of 147 inpatient rehabilitation beds in the service area of Davidson and Wilson Counties.

It appears that the application does not meet criteria 1 and 2.

11 Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.

The applicant, SMC, has chosen Davidson and Wilson Counties as the service area for its inpatient rehabilitation service, which has received approximately 82% of its admissions from residents of these two counties.

It appears that the application does meet this criterion.

12 Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.

The SMC application for a Rehab Unit is for 12 beds.

It appears that the application meets this criterion.

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.

This criterion is not applicable.

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HSDA, unless all existing units or facilities are utilized at the following levels:

20-30 bed unit ~ 75%
31-50 bed unit/facility ~ 80%
51 bed plus unit/facility ~ 85%

Currently, there are five inpatient rehabilitation services operating in Davidson and Wilson Counties. Below is a comparison of how the utilization of the 183 operating and staffed beds in 2011 compared with the 2000 Edition of the Guidelines for Growth's occupancy standards. None of the existing inpatient rehabilitation services are meeting the occupancy standards. The 10 unstaffed beds at Skyline Madison and the 31 inactive beds at Nashville Rehabilitation reported no utilization in 2011.

Bed Unit Range	***G of G* Occupancy Standard***	***Hospital/County***	***2011 Rehab Bed Capacity***	***2011 Occupancy***	***Meets G of G* Standard***
20-30 beds	*~ 75%*	*Southern Hills Medical Center/Davidson*	*12 beds*	*69.2%*	*No*
20-30 beds	*~ 75%*	*Baptist Hospital/Davidson*	*24 beds*	*69.0%*	*No*
20-30 beds	*~ 75%*	*McFarland Hospital/Wilson*	*26 beds*	*29.4%*	*No*
31-50 bed unit/facility	*~ 80%*	*Skyline Medical Center/Davidson*	*41 beds*	*75.1%*	*No*
51 beds plus	*~ 85%*	*Vanderbilt Stallworth/Davidson*	*80 beds*	*76%*	*No*

**G of G = Guidelines for Growth*

It appears that the application does not meet this criterion.

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board certified physiatrist.

The applicant states that the proposed staffing will conform to licensure requirements. The applicant also intends to seek a Board-certified physiatrist as medical director of the rehabilitation unit.

It appears that the application intends to meet this criterion.

SUMMARY:

SMC proposes to place the 12-bed rehabilitation unit and the 8 medical/surgical beds in space that currently houses a 20 bed adult psychiatric unit on the third floor of the hospital. The rehabilitation unit will be T-shaped with two wings housing 12 private patient rooms (6 on each wing), an Activity of Daily Living (ADL) suite with a kitchen, bedroom, and bath; a Day/Dining room, a physical therapy exercise room, a central nursing station, and other patient/staff support areas. The third wing will house a speech therapy room, physician office with exam room, a conference room/library, a patient salon, and staff offices/lounge. The fourth wing will contain 8 private rooms for orthopedic surgery patients. The square footage of the renovated third floor is 22,218 square feet.

The current bed mix at SMC compare to the proposed bed mix is displayed in the table below:

Bed Type	Current Beds	Proposed Beds	# Change
Med./Surg.	110	118	+8
Obstetrical	24	24	0
ICU/CCU	24	24	0
NICU	10	10	0
Adult Psych.	20	0	-20
Rehab.	0	12	+12
TOTAL	188	188	0

The applicant provides several reasons on why the proposed project is needed:

- Existing medical/surgical patients (amputation, stroke, burns, major trauma, joint replacements, etc.) will be able to receive rehabilitation services on the same campus.
- Recent expansion of emergency department and designation as a Joint Commission-designated Primary Stroke Center.
- Over 10% increase in emergency department visits, inpatient admissions through the emergency department, and discharges to existing inpatient rehabilitation services between 2011 and 2012
- Patients/families prefer rehabilitation services closer to home. The applicant believes that the patient/family "closer to home preference" has resulted in a shift of rehabilitation admissions from downtown facilities to suburban locations. The applicant displayed this shift in the application through the following chart:

Applicant's Illustration of Movement of Rehabilitation Patient Days

Movement of Rehabilitation Patient Days in Davidson County CY2008-CY2011			
Location	CY 2008	CY 2011	Change '08-'11
Central County*	33,199 (80%)	28,221 (68%)	-15%
Suburban County Areas**	8,329 (20%)	13,071 (32%)	+56%
Totals	41,528	41,292	

*Central providers were Vanderbilt Stallworth, Baptist, & Nashville Rehabilitation Hospital

** Suburban providers were Skyline and Southern Hills Medical Centers.

Source: Joint Annual Reports, 2008-2011.

- Resource disparity within greater Nashville. Eastern Davidson County is the only suburban area with a local hospital that does not offer inpatient acute rehabilitation services.
- The proposed project will not have a major adverse impact on other rehabilitation providers in Davidson or Wilson Counties including nursing homes. The applicant states that acute care patients discharged from SMC not requiring hospital-level intensity of rehabilitation (3 hours or more per day) will continue to be referred to nursing home programs.
- The fifth floor surgical unit operated at a weekday occupancy of 78% in 2012. On 23% of these weekdays occupancy on this unit was greater than 90%. By moving the orthopedic patients into a specialized unit on the third floor, SMC can relieve occupancy pressures in the fifth floor nursing staff.

Summit Medical Center is 100 percent owned by HCA Health Services of Tennessee, whose parent organization is (through several corporate entities) HCA, Inc of Nashville, Tennessee. HCA is composed of locally owned facilities that include approximately 190 hospitals and 82 outpatient surgery centers in 23 states, England and Switzerland. Summit Medical Center is part of the locally managed HCA TriStar Group which operates hospitals in South Central Kentucky, Northern Georgia, and fourteen (14) hospitals in Tennessee. An organizational chart is enclosed in Attachment A.4.

According to the Joint Annual Report, Summit Hospital is licensed for 188 beds and staffs all of its beds. The licensed and staffed hospital bed occupancy at Summit Medical Center was 58% respectively in 2011. The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

Licensed Beds- The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken

down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).

Staffed Beds-The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.

The rehabilitation bed landscape in Davidson County has undergone several changes since 2006, especially for HCA facilities as detailed below:

- Prior to 2006 HCA had only 25 rehabilitation beds at Centennial Medical Center and 22 rehabilitation beds at Skyline Medical Center. In 2007 Centennial filed a major construction project that includes the conversion of the 25 rehabilitation beds to medical/surgical beds.
- In 2006 HCA acquired 273-bed Tennessee Christian Medical Center in Madison (Davidson County). It was combined with Skyline Medical Center as a satellite campus. At the time of the acquisition this facility had 50 rehabilitation beds. HCA suspended all non-behavioral health inpatient admissions, including rehabilitation. To date 40 of these rehabilitation beds have been delicensed in conjunction with other projects resulting in the redistribution of rehabilitation beds including:
    - CN0704-026, Skyline Medical Center-Relocate 9 rehabilitation beds from the satellite campus to the main campus. This increased the rehabilitation bed complement at the main campus from 22 to 31.
    - CN0808-062, Skyline Medical Center-Relocate 10 rehabilitation beds from the satellite campus to the main campus. This increased the rehabilitation bed complement at the main campus from 31 to 41.
    - CN1003-014, Southern Hills Medical Center-The initiation of a 12 bed rehabilitation unit. Skyline-Madison satellite campus delicensed 12 of its rehabilitation beds in conjunction with this project leaving it with a rehabilitation bed complement of 10. These 10 beds remained unstaffed.
- In 2010 Middle Tennessee Rehabilitation Hospital filed CN1012-057 for a 31 bed rehabilitation hospital in Williamson County by relocating the 31 rehabilitation bed Nashville Rehabilitation Hospital located in East Nashville. The Agency denied this application at its March 23, 2011 Meeting. The applicant appealed the Agency's decision and this application remains a contested case. Nashville Rehabilitation Hospital's license for the 31 bed facility was placed in an inactive status by the Tennessee Department of Health, Board for Licensing Health Care Facilities. The inactive status has been extended until January 2014.

- In 2011 Southern Hills Medical Center filed CN1111-048, which the Agency approved at its February 22, 2012 meeting for the conversion of 4 medical/surgical beds to rehabilitation beds to increase its rehabilitation bed complement to 16.
- In 2012 the applicant, Summit Medical Center, filed CN1206-029 for the conversion of a 20 bed adult psychiatric unit to a 20 bed rehabilitation unit. The Agency denied this request at its September 26, 2012 meeting. The reasons given for the denial included that the need and the orderly development of adequate and effective health aspects of this application failed to meet the established criteria.

The current distribution of rehabilitation beds in Davidson and Wilson County are displayed in the table below:

Inventory of Inpatient Rehabilitation Beds in Davidson and Wilson Counties

Hospital	Licensed Acute Care Beds Certified as Inpatient Rehabilitation Beds	Current Status
Southern Hills Medical Center	16	Licensed & Operational
Baptist	24	Licensed & Operational
Vanderbilt Stallworth	80	Licensed & Operational
Skyline Medical Center	41	Licensed & Operational
McFarland Hospital	26	Licensed & Operational
Subtotal - Operational	**183**	**Currently Licensed & Operational**
Skyline Medical Center - Madison	10	Licensed, but not operational
Nashville Rehabilitation Hosp.	31	Licensed, but inactive
Subtotal – Licensed, not operating	**41**	**Licensed, but not operational**
Total Licensed, Certified Rehab Beds	**228**	Licensed & Certified Rehab Beds

Source: Tennessee Department of Health and Health Services and Development Agency Records

SMC's primary service area is Davidson and Wilson Counties, from which approximately 84% of SMC's admissions originate. Davidson County contributed 55.8% of SMC admissions, while Wilson County added another 28.4% in 2011. The applicant indicates that HCA TriStar's experience is the great majority of its rehabilitation units' admissions are patients discharged from the hospital of which they are a part, and, therefore, they believe Davidson and Wilson Counties will also be the primary service area for the proposed rehabilitation service.

Population projections based on the 2010 US Census from the Tennessee Department of Health's Division of Health Statistics indicates that the general population of the applicant's primary service area in 2013 is estimated to be 771,133 and is expected to grow 4.7% to 807,249 by 2017. This growth rate

compares to the State's growth rate of 3.7% for the same time period. The age 65+ population in the service area is expected to increase by 16.4% from 88,916 to 103,528 individuals during this time period compared to a statewide growth rate of 14.9%. In 2017, individuals age 65+ are expected to account for approximately 12.8% of the two county service area population compared to 16.1% for Tennessee. The number of TennCare enrollees residing in the service area equates to 17.4% of the population, with Davidson County having the largest population proportion of TennCare enrollees (18.4%) and Wilson County having the lowest proportion (11.8%).

In applying the *Guidelines for Growth's* bed need formula, the following calculations result: the need for rehabilitation beds is 81 beds, while the current supply of licensed beds which are certified and approved as rehabilitation beds is 228, leaving a surplus of 147 beds.

The applicant provides a chart on page 19 of the application of the driving distances and times from Summit Medical Center to the other hospitals with inpatient rehabilitation programs. None of the hospitals are further than 21 miles, nor more than 27 minutes driving time.

A summary of the historical utilization of inpatient rehabilitation services is presented in the charts below. These charts will also provide sub-totals for central county providers and suburban providers as defined by the applicant.

Service Area Inpatient Rehabilitation Bed Patient Day Trends

Hospital/County	2013 Beds	2008	2009	2010	2011	'08 –'11 # Change	'08 –'11 # Change
Baptist/Davidson	24	6,135	6,783	6,578	6,041	-94	-1.5%
Nashville Rehab/Davidson (1)	31	4,831	0	0	0	-4831	-100.0%
Vand. Stallworth/Davidson	80	22,233	22,393	22,671	22,180	-53	-0.2%
Central County Sub-Total	**135**	**33,199**	**29,176**	**29,249**	**28,221**	-4,978	-15.0%
Skyline/Davidson (2)	41	8,329	10,150	10,804	11,306	+2,977	35.8%
Southern Hills/Davidson (3)	16	0	0	0	1,765	+1,765	+100.0%
Skyline Madison/Davidson (4)	10	0	0	0	0	0	0
Suburban Co. Sub-Total	**67**	**8,329**	**10,150**	**10,804**	**13,071**	+4742	+57.0%
McFarland/Wilson	26	2,762	2,529	2,641	2,794	+32	+1.2%
TOTAL	**228**	**44,290**	**41,855**	**42,645**	**44,086**	-204	-0.5%

Service Area Inpatient Rehabilitation Bed Occupancy Trends

Hospital/County	2013 Beds	2008	2009	2010	2011	Met Occupancy Standard in 2011?/Standard
Baptist/Davidson	24	70.0%	77.4%	75.0%	69.0%	No/75%
Nashville Rehab/Davidson (1)	31	39.0%	0	0	0	No/80%
Vand. Stallworth/Davidson	80	76.1%	75.9%	77.6%	76.0%	No/85%
Central County Sub-Total	**135**	**67.3%**	**59.2%**	**59.4%**	**57.3%**	**NA**
Skyline/Davidson (2)	41	73.6%	67.8%	72.2%	75.5%	No/80%
Southern Hills/Davidson (3)	16	0	0	0	69.2%	No/75%
Skyline Madison/Davidson (4)	10	0	0	0	0	No/75%
Suburban Co. Sub-Total	**67**	**36.2%**	**44.1%**	**47.0%**	**49.2%**	**NA**
McFarland/Wilson	26	29.1%	26.6%	27.8%	29.4%	No/75%
***TOTAL**	**228**	**53.5%**	**51.2%**	**52.2%**	**53.9%**	**NA**

****Includes all certified inpatient rehabilitation beds including 41 non-operational beds***

(1) Discontinued operation in 2009. Beds currently licensed but inactive

(2) Skyline Medical Center – Madison transferred 10 certified/licensed inpatient rehabilitation beds in 2009 to Skyline Medical Center –Main Campus (CN0808-062A)

(3) Skyline Medical Center – Madison transferred 12inpatient rehabilitation beds to Southern Hills Medical Center (CN1003-014A) granted in 2010, but implemented on 6/1/2011. Southern Hills granted 4 additional inpatient rehabilitation beds in 2012 (CN1111- 048) and implemented in February 2013.

(4) *Had 32 certified rehabilitation beds in 2008. Reduced to 22 after implementation of CN0808-062A and reduced further to 10 beds after implementation of CN1003-014A. Has not operated rehabilitation beds since 2006 when acquired by HCA*

Source: TN Department of Health, Joint Annual Report, 2008-2011

Of the seven (7) short-term, acute care hospitals within SMC's declared service area, the number of hospitals which are currently providing inpatient rehab services is five (5). The applicant has noted that the rehabilitation services in the central part of the county (Baptist, Vanderbilt Stallworth, and Nashville Rehab) have experienced declining utilization of approximately 15% between 2008 and 2011. A review of the patient day chart above indicates that the decline is mainly due to the inactive status of the Nashville Rehab beds. Utilization at Vanderbilt Stallworth and Baptist has experienced a slight decline, both less than 2%. The applicant also notes that utilization has increased 57% in suburban rehabilitation services (Skyline and Southern Hills). This increase in utilization has come with the increase of rehabilitation beds at both Skyline-Main Campus and Southern Hills. The increase in patient days at these facilities has been comparable to the days that were provided at Nashville Rehabilitation before it went into inactive

status. Rehabilitation bed occupancy has remained fairly constant between 2008 and 2011. There are 41 rehabilitation beds that are currently not in operation; 31 beds at Nashville Rehabilitation and 10 beds at Skyline-Madison. Utilization has remained relatively constant at McFarland Hospital since 2008, operating between 25% - 30% occupancy.

Note to Agency members: Rehabilitation utilization has been impacted by the change in Medicare reimbursement implemented by the Centers for Medicare and Medicaid Services (CMS). As a participant in the Medicare program, the inpatient rehabilitation facility is required to show a minimum percentage of the facility's total patient population must meet one of thirteen (13) medical conditions. Initially the compliance threshold was 75% (known as the "75% rule'), but was later modified in 2006 to "60% threshold" of the rehabilitation unit's patient population. The CMS' "threshold Rule" for rehabilitation facilities essentially divided rehab patients into two categories: (1) those who are being treated for one or more of 13 specified conditions, i.e., acute care patients and (2) those not receiving treatment for any of the 13 specified conditions, or non-acute rehab patients. Under the new 60% Rule, Medicare reimbursement is available to an inpatient rehabilitation facility only if, on an annual basis, 60% of its patients are acute rehab patients. The 13 specified conditions include: Stroke; Spinal Cord Injury; Amputation; Major Multiple Trauma; Fracture of the Femur (hip fracture); Brain Injury; Neurological Disorders; Burns; Active Polyarticular Rheumatoid Arthritis; Congenital Deformities; Systemic Vasculidities; Severe or Advanced Osteoarthritis; Hip and Knee Replacements accompanied by extreme obesity with a body mass index of at least 50, or be 85 years of age or older.

Source: CMS Fact Sheet #1 Inpatient Rehabilitation Facility Classification Requirements
S.2499 2007 Medicare, Medicaid, and SCHIP Extension Act

The applicant has stated that the utilization of inpatient psychiatric beds at SMC will be absorbed by Skyline-Madison. In 2008 the SMC 20-bed unit had 4,377 patient days and operated at 60% occupancy and had 5,003 patient days and operated at 68.5% occupancy in 2011. The applicant expects that the adult inpatient unit at Skyline-Madison will be able to absorb this volume. According to its Joint Annual Reports, Skyline Madison operated 89 inpatient psychiatric beds in 2008, reported 19,707 patient days for an occupancy rate of 60.7%. In 2011 it reported operating 96 inpatient psychiatric beds with 22,909 patient days with an occupancy of 65.4%. The applicant states that combining Summit's utilization in 2012 with Skyline Madison's utilization in 2012 would have resulted in an occupancy rate of 78%

The applicant projects that the proposed rehabilitation unit will experience 270 admissions and 3,645 patient days (83.3% occupancy) in the first year and 284 admissions and 3,834 patient days (87.6% occupancy) in the second year. The

details of the applicant's methodology can be found on pages 39-41 of the original application.

The applicant states that the proposed project will have minimal impact on non-HCA rehabilitation providers since the majority of SMC's discharges to acute rehabilitation programs were to sister HCA hospitals. The applicant stated that patients requiring less intensive rehabilitation services will continue to be referred to area nursing homes. The applicant provides a breakdown of the referral destination for inpatient rehabilitation services for 195 patients in 2012. The applicant also notes that the 195 patients referred to existing area inpatient rehabilitation units in 2012 was a 10.8% increase from 176 patients in 2011:

Facility	2012 Summit Rehabilitation Discharges	% Total
Other TriStar	126	64.6%
McFarland	22	11.3%
Vand. Stallworth	20	10.3%
Other	20	10.3%
Baptist	4	2.0%
Sumner Reg.	3	1.5%
TOTAL	195	100%

The applicant indicates its average gross charge per day for the inpatient rehabilitation unit will be $3,259 in year one and $3,390 in the second year. With the average deduction from operating revenue of approximately 59% of charges, SMC anticipates the Average Operating Net Revenue per day will be $1,338 in the first year and $1,367 in year two. Net Operating Income less Capital Expenditures is projected to be $1,579,076 in the first year and $1,716,222 in the second year.

The applicant indicates it plans to staff the rehabilitation unit with 23.55 FTEs of clinical and rehabilitation staff in year one, adding 2.45 FTEs to the staffing mix in year two for a total of 26.0FTE. The applicant expects to have 9.4 FTEs to staff the 8-bed orthopedic unit in Year 1 increasing to 9.52 FTE in Year 2.

The applicant anticipates that the rehabilitation unit will generate $7,504,640 in Medicare gross revenues and constitute 52% of its payor mix in year one, while TennCare will contribute gross revenues of $356,400 and comprise 3% of its gross revenues the first year. The applicant indicates they have contracts with all three

TennCare MCOs available to its service area population: United HealthCare Community Plan (formerly AmeriChoice), TennCare Select and AmeriGroup.

Review of SMC's Historical Data Chart indicates the hospital has experienced several profitable years during the 3 years reported (2010-12). Net Operating Income less Capital Expenditures has been $10,890,220 in 2010, $12,414,115 for 2011, and $18,407,255 in 2012.

The source of funding for the project is identified as a cash transfer from the applicant's parent (HCA, Inc.) to the applicant's division office (TriStar Health System). A 04/10/13 letter from HCA TriStar's Chief Financial Officer attests to HCA's ability to finance the project. Review of the HCA's Holdings financial statement as of 09/30/12 revealed current assets of $7.272 billion and current liabilities of $5.861 billion for a current ratio of 1.24:1. Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

The total estimated project cost is $4,933,576. The majority of the cost (67%) is the renovation cost ($3,293,660). Related costs include $255,342 contingency fund and $89,500 for architectural and engineering fees. Other costs include $685,000 for moveable equipment, $385,000 for information technology and telecommunications, $63,998 for interim financing, and $50,000 for administrative costs.

The applicant has submitted the required corporate documentation and real estate title. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.

Should the Agency vote to approve this project, the CON would expire in three years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent or pending applications for this applicant.

HCA has financial interests in this project and the following:

Denied Applications:

Summit Medical Center, CN1206-029D, was denied at the September 26, 2012 Agency meeting. The application was for the for the establishment of a 20 bed acute inpatient rehab unit and service in its hospital facility by converting 20 adult psychiatric beds and reclassifying the adult psychiatric unit to an inpatient rehab unit. The estimated cost was projected to be **$2,500,000.00** *Reason for Denial: The application did not meet the statutory criteria.*

Spring Hill Hospital, Spring Hill (Maury County), TN, CN0804-031D, was denied at the July 23, 2008 Agency Meeting. The application was for the acquisition of a linear accelerator and the initiation of linear accelerator services at an unaddressed site on the NE corner of the intersection of Saturn Parkway and Kedron Road in Spring Hill, (Maury County), Tennessee. This project was filed as a simultaneous review of Vanderbilt Maury Radiation Oncology, L.L.C., CN0804-024. The estimated cost was projected to be **$7,500,614.00.** *Reason for Denial: The approval of Vanderbilt Maury Radiation Oncology, LLC satisfied the need for additional capacity.*

Stonecrest Medical Center, CN0809-072D, was denied at the December 17, 2008 Agency meeting. The application was for the construction of a six (6) bed neonatal intensive care unit (NICU) and the initiation of Level II-B NICU services. Stonecrest Medical Center is authorized for one hundred one (101) hospital beds. This project was to add another six (6) licensed NICU beds increasing the hospital's authorized bed complement to one hundred seven (107) beds. Estimated project cost was **$2,774,900.** *Reason for Denial: The application did not meet statutory criteria. Note to Agency members: Since this denial an eight (8) bed NICU was approved, CN1107-026A, which is further described in the "Outstanding Certificate of Need" section below.*

Outstanding Certificates of Need

Hendersonville Medical Center, CN1302-002, has an outstanding Certificate of Need which will expire on August 1, 2016. It was approved at the June 26, 2013 Agency meeting to construct a new fourth floor of medical surgical beds and initiate Level IIB Neonatal Intensive Care services in a new six (6) licensed Level IIB Neonatal Intensive Care Unit (NICU) on its campus at 355 New Shackle Island Road, Hendersonville (Sumner County) Tennessee, 37075. The proposed project will not change the total licensed bed complement. The hospital currently holds a single consolidated license for 148 general hospital beds, of which 110 are located at its main Hendersonville campus and 38 are located at its satellite campus at 105 Redbud Drive, Portland (Sumner County), TN 37148. The applicant will relocate 13 beds from the satellite campus to the main campus,

resulting in 123 licensed beds at the Hendersonville campus and 25 licensed beds at the Portland satellite campus. The estimated cost of the project is **$32,255,000.00.** *Project Status: Recently approved.*

Natchez Surgery Center, CN1002-011A, has an outstanding Certificate of Need which will expire on July 1, 2015. It was approved at the May 26, 2010 Agency meeting for the establishment of an ambulatory surgical treatment center (ASTC) with three (3) operating rooms and three (3) procedure rooms. After approval, CN801-001A was surrendered which was a similar facility for this site at 107 Natchez Park Drive, Dickson (Dickson County), TN. The estimated cost of the project was **$13,073,892.00.** *Project Status: The applicant requested a modification at the March 2012 Agency meeting to extend the expiration date for three (3) years from July 1, 2012 to July 1, 2015,; reduce the number of operating rooms from three (3) to two (2) and procedure rooms from three (3) to one (1); reduce project costs by $4,201,823 from $13,073,892 to $8,872,069; and reduce square footage by 4,965 from 15,424 to 10,459 square feet. The Agency approved the modifications and extension of the expiration date to July 1, 2015. The February 5, 2013 Annual Progress Report indicated construction has not begun but will coincide with the development of a Free Standing Emergency Department to be operated as a department of Horizon Medical Center, as authorized by CN1202-008A. The applicant anticipates the ASTC will be completed by the July 1, 2015 expiration date.*

StoneCrest Medical Center, CN1107-026A, has an outstanding Certificate of Need that will expire on December 1, 2014. The CON was approved at the October 26, 2011 Agency meeting to modify its existing facility and add eight (8) licensed Level IIB Neonatal Intensive Care Unit (NICU) beds to its existing one hundred and one (101) licensed acute care bed complement. Upon completion of this project, the total licensed acute care bed capacity of the hospital will be one hundred and nine (109) beds. Upon licensure of these eight (8) beds, eight (8) beds at other HCA facilities will be delicensed. The estimated project cost is **$2,991,463.00**. *Project Status: The NICU opened on May 20, 2013. The applicant expects to file the Final Project Progress Report around August 1, 2013.*

Skyline Medical Center (Madison Campus), CN1110-040A, has an outstanding Certificate of Need which will expire on March 1, 2015. It was approved at the January 25, 2012 Agency meeting for expansion of an existing inpatient adolescent psychiatric unit by eleven (11) beds through the conversion of eleven (11) existing Medical/Surgical beds at its Madison Campus. The result will be a twenty-one (21) adolescent psychiatric bed unit while the hospital's total licensed bed complement of four hundred forty-six (446) acute care beds will remain unchanged. The estimated cost of the project is **$2,412,504.00.** *Project Status Update: An annual progress report dated March 28, 2013 indicates a general contractor has been selected and the anticipated project completion date is December 31, 2013.*

Parkridge Medical Center, CN1202-005, has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the relocation of 16 of 25 currently licensed geriatric psychiatric beds to a new satellite campus, (2) the conversion of the remaining 9 geriatric psychiatric beds to medical/surgical, and (3) the addition of 16 acute medical surgical beds. The licensed bed complement at Parkridge Medical Center will remain at 275 beds. The net result of this application is that this site will operate as a general acute hospital with no psychiatric services on site. Estimated project cost is **$1,010,500.** *Project Status Update: A May 2013 update indicated that the project's completion date was expected to be in June 2013.*

Parkridge Valley Hospital, CN1202-006 has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the addition of sixteen (16) additional child and adolescent psychiatric beds to the sixty-eight (68) beds currently located on the satellite campus at 2200 Morris Hill Road, Chattanooga (Hamilton County) and (2) the relocation of all forty-eight (48) of its licensed adult psychiatric beds to a new campus. The current licensed hospital bed complement at Parkridge Valley Hospital, which is a satellite location of Parkridge Medical Center, will decrease from one hundred sixteen (116) beds to eighty-four (84) beds. The net result of this application is that only child and adolescent psychiatric beds will operate at this location. Estimated project cost is **$143,000.** *Project Status Update: A May 2013 update indicated that the project's completion date was expected to be in June 2013.*

Parkridge Valley Adult Services, CN1202-007A, has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the relocation of forty-eight (48) adult psychiatric beds from Parkridge Valley Hospital to a new campus to be called Parkridge Valley Adult Services located at 7351 Standifer Gap Road, Chattanooga (Hamilton County); and (2) the relocation of sixteen (16) geriatric psychiatric beds from Parkridge Medical Center to the new Adult Services campus. Parkridge Valley Adult Services will operate as a sixty-four (64) bed satellite hospital of Parkridge Medical Center. The net result of this application is that all adult (including Geriatric) psychiatric services will operate at this site. Estimated project cost is **$6,762,622.** *Project Status Update: An update received May 13, 2013 indicated that service at the new campus was expected to begin in June 2013.*

Horizon Medical Center Emergency Department, CN1202-008A, has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting to establish a satellite emergency department facility located at its Natchez Medical Park campus located at 109

Natchez Park Drive, Dickson (Dickson County). Estimated project cost is **$7,475,395.** *Project Status Update: Per a June 27, 2013 Annual Progress Report the project is on schedule. An architect has been selected and schematic plans have been prepared. Selection of a contractor is in the final stages. Pre-construction development of the site is complete and the site is ready for grading. Groundbreaking should commence by December 31, 2013.*

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, denied or pending applications for other entities proposing this type of service.

Vanderbilt Medical Center, CN0606-037A, has an outstanding certificate of need that will expire on July 1, 2015. The CON was approved at the September 27, 2006 Agency meeting for the continuance of facility's master plan: addition of 3rd bed tower with redistribution of 141 SNF beds to acute care beds; renovation and expansion of cardiac cath labs and hybrid ORs; addition of 14 newly constructed OR suites; and decommissioning 2 ORs. **The estimated project cost is $234,421,471.00.** *Project Status Update: A June 17, 2013 Annual Progress Report states construction continues on the fifth and second floors of the third bed tower project. The fifth floor includes the relocated cardiac catheterization labs and the second floor contains patient amenities. All bed floors are complete, licensed and in operation.*

Saint Thomas Medical Center, CN1110-037A, has an outstanding certificate of need that will expire on March 1, 2017. The application was approved at the January 25, 2012 Agency meeting for the 3-phase hospital renewal project for various services and area: renovation of 89,134 SF of hospital space; construction an adjoined 6-level 135,537 SF patient tower; and the addition of a GE Discovery CT scanner. The estimated project cost is **$110,780,000.** *Project Status Update: A February 2013 update states the first phase of the project (C wing) had all low-voltage cabling removed as well as some other minor demolition. The wing (approximately 8,500 SF) is currently being prepared for demolition to begin on March 4, 2013. This phase will be complete with Construction on June 18, 2013 and open for patients on July 1, 2013.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

MAF (07/15/13)

LETTER OF INTENT

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

2013 APR 8 PM 4 11

The Publication of Intent is to be published in the Nashville Tennessean, which is a newspaper of general circulation in Davidson County, Tennessee, on or before April 10th, 2013, for one day.

---

interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to convert eight (8) inpatient psychiatric beds to medical-surgical beds, and to convert twelve (12) inpatient psychiatric beds into a new twelve (12) bed acute inpatient rehabilitation unit and service at its campus, at 5655 Frist Boulevard, Hermitage, TN 37076. Inpatient psychiatric services will no longer be provided at Summit Medical Center. The estimated capital cost is $5,000,000.

TriStar Summit Medical Center is a general hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 188 hospital beds. The project will not change its licensed hospital bed complement. It will not initiate or discontinue any health service other than described above, or add any major medical equipment. Upon opening of the Summit rehabilitation unit, TriStar Skyline Medical Center will delicense ten (10) acute inpatient rehabilitation beds at its satellite campus at 500 Hospital Drive, Madison, TN 37115.

The anticipated date of filing the application is on or before April 15, 2013. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215; (615) 665-2022.

John L. Wellborn 4-8-13 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

ORIGINAL APPLICATION

SUMMIT MEDICAL CENTER

CERTIFICATE OF NEED APPLICATION TO ESTABLISH A 12-BED ACUTE INPATIENT REHABILITATION UNIT AND AN 8-BED ORTHOPEDIC UNIT THROUGH BED CONVERSIONS

Submitted April 2013

SUPPLEMENTAL

PART A

1. Name of Facility, Agency, or Institution

Summit Medical Center		
Name		
5655 Frist Boulevard		Davidson
Street or Route		*County*
Hermitage	TN	37076
City	*State*	*Zip Code*

2. Contact Person Available for Responses to Questions

John Wellborn		Consultant	
Name		*Title*	
Development Support Group		jwdsg@comcast.net	
Company Name		*E-Mail Address*	
4219 Hillsboro Road, Suite 203	Nashville	TN	37215
Street or Route	*City*	*State*	*Zip Code*
CON Consultant	615-665-2022	615-665-2042	
Association With Owner	*Phone Number*	*Fax Number*	

3. Owner of the Facility, Agency, or Institution

HCA Health Services of Tennessee, Inc.		615-441-2357
Name		*Phone Number*
Same as in #1 above		
Street or Route		*County*
Hermitage	TN	37076
City	*State*	*Zip Code*

4. Type of Ownership or Control (Check One)

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	
D. Corporation (For-Profit)	x	I. Other (Specify):	
E. Corporation (Not-for-Profit)			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

SUPPLEMENTAL

5. *Name of Management/Operating Entity (If Applicable)* NA

Name

Street or Route *County*

City *State* *Zip Code*

6. *Legal Interest in the Site of the Institution (Check One)*

A. Ownership	x	D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of ____ Years			

7. *Type of Institution (Check as appropriate—more than one may apply)*

A. Hospital (Specify): General	x	I. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty		J. Outpatient Diagnostic Center	
C. ASTC, Single Specialty		K. Recuperation Center	
D. Home Health Agency		L. Rehabilitation Center	
E. Hospice		M. Residential Hospice	
F. Mental Health Hospital		N. Non-Residential Methadone	
G. Mental Health Residential Facility		O. Birthing Center	
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)		P. Other Outpatient Facility (Specify):	
		Q. Other (Specify):	

8. *Purpose of Review (Check as appropriate—more than one may apply*

A. New Institution		G. Change in Bed Complement Please underline the type of Change: Increase, Decrease, Designation, Distribution, Conversion, Relocation	x
B. Replacement/Existing Facility		H. Change of Location	
C. Modification/Existing Facility	x	I. Other (Specify):	
D. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify) *Acute IP Rehabilitation*	x		
E. Discontinuance of OB Service			
F. Acquisition of Equipment			

9. *Bed Complement Data*

(Please indicate current and proposed distribution and certification of facility beds.)

	Current Licensed Beds	CON approved beds (not in service)	Staffed Beds	Beds Proposed (Change)	TOTAL Beds at Completion
A. Medical	110		110	+8	118
B. Surgical					
C. Long Term Care Hosp.					
D. Obsetrical	24		20		24
E. ICU/CCU	24		18		24
F. Neonatal	10		10		10
G. Pediatric					
H. Adult Psychiatric	20		20	-20	0
I. Geriatric Psychiatric					
J. Child/Adolesc. Psych.					
K. Rehabilitation	0			+12	12
L. Nursing Facility (non-Medicaid certified)					
M. Nursing Facility Lev. 1 (Medicaid only)					
N. Nursing Facility Lev. 2 (Medicare only)					
O Nursing Facility Lev. 2 (dually certified for Medicare & Medicaid)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child/Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	**188**	**0**	**178**	**0**	**188**

10. Medicare Provider Number:	440150
Certification Type:	general hospital
11. Medicaid Provider Number:	44-0205
Certification Type:	general hospital

12. & 13. See page 4

A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

This is an existing facility already certified for both programs. In CY2012, Summit Medical Center had an overall payor mix of 44.4% Medicare and 10.7% TennCare.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

Summit Medical Center is fully contracted with all available TennCare MCO's in the Middle Tennessee Region. They are as follows:

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
AmeriGroup	contracted
United Community Healthcare Plan (formerly AmeriChoice)	contracted
Select	contracted

SECTION B: PROJECT DESCRIPTION
B.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.

Proposed Services and Equipment

• TriStar Summit Medical Center is a highly utilized 188-bed community hospital located beside I-40 in Hermitage, Tennessee, in far eastern Davidson County. It is the only general hospital between downtown Nashville and Lebanon (in Wilson County).

• The project converts 20 adult psychiatric beds on the hospital's third floor into an 8-bed orthopedic surgical unit, and a new acute rehabilitation unit of 12 beds. This conversion will not increase the hospital's licensed bed complement. When Summit's project opens, TriStar Skyline Medical Center will delicense 10 rehabilitation beds at its Madison campus (in northern Davidson County), and will take Summit's psychiatric patients into its much larger adult psychiatric program at that campus. This will reduce the county's total licensed hospital beds by 10.

Ownership Structure

• Summit Medical Center is an HCA TriStar facility owned by HCA Health Services of Tennessee, Inc., whose ultimate parent company is HCA, Inc. Attachment A.4 contains details, an organization chart, and information on Tennessee facilities owned by HCA.

Service Area

• The project's primary service area will reflect the hospital's primary service area. That area consists of Davidson and Wilson Counties. Approximately 82% of Summit's admissions come from those counties, with no other county contributing as much as 3%.

Need--*Rehabilitation Unit*

• Summit's discharges to other hospital's rehabilitation units are high, due not only to local population growth, but also to the hospital's recent Emergency Department expansion and its designation as one of Tennessee's 18 Certified Primary Stroke Centers. Having in-house acute rehabilitation is a state-of-the-art commitment to a full continuum of stroke treatment. Stroke intervention and care are high priorities for the State's physician community (see Attachments from the Tennessee Medicine Journal).

• The utilization of available rehabilitation beds in Davidson County is at efficient levels. The county's four operational acute rehabilitation programs provided 41,292 days of care in 2011 (complete 2012 data is not available at the time of filing this application). That was 72.1% occupancy on the 157 rehabilitation beds that were open in 2011. Some additional older rehabilitation beds exist in Davidson County, but they have been unstaffed for several years and are unlikely to open in the future.

• The project supports past CON approvals and market trends to move rehabilitation resources closer to patients' homes. Rehabilitation utilization in Davidson County has been shifting to suburban locations. Between 2008 and 2011, the total rehabilitation days provided in the downtown area decreased 15%, while the rehabilitation days provided in the Davidson County suburbs increased 56%.

• The project corrects a disparity of resources in the Nashville urban area. Acute rehabilitation beds have been approved for northern and southern Davidson County hospitals, along with hospitals in the urbanizing areas west and south of Davidson County--but they have not yet been approved in eastern Davidson County. TriStar Summit Medical Center in Hermitage is the logical hospital to provide acute rehabilitation within the eastern sector of the urban area, because it is the only hospital in eastern Davidson County. The closest alternative is 21 miles farther east in the center of adjoining Wilson County.

• At only 12 beds, the project will be filled with patients who meet the requirement of being able to undergo 3 hours of rehabilitation therapies per day. The project will not significantly impact the lower-intensity nursing home rehabilitation programs in the area. They will continue to receive rehabilitation referrals from Summit. Summit's plan is to strengthen collaboration with area nursing homes, as attested by letters of support for this application. With such collaboration, the project will provide greater efficiency and quality of care for patients than currently exist.

Need--*Orthopedic Unit*

• The hospital is seeking Joint Commission accreditation as a Total Joint Center of Excellence. A dedicated orthopedic nursing unit will enhance specialized nursing care and improve outcome management.

• Conversion of underutilized beds is the fastest way to achieve much-needed surgical bed capacity. In CY2012, Summit's surgical beds averaged 78% occupancy on weekdays. On almost half those weekdays, occupancy exceeded 80%, often reaching 100%. Medical-surgical bed occupancy in 2012 exceeded 83%. In contrast, the psychiatric unit being converted had only 59% occupancy in CY2012.

Existing Resources

• There are seven hospitals in the primary service area with licensed rehabilitation beds. But only five of those programs are open for patient care. As of February 2013, those five programs offered 161 rehabilitation beds (an increase of 4 beds from the prior year). The two non-operational programs now have 41 licensed, but unusable or unstaffed, rehabilitation beds.

Project Cost, Funding, Financial Feasibility, and Staffing

• The estimated cost of the project is $4,933,576, which will be provided through a cash transfer from Summit's parent company, HCA. Summit's utilization ensures that both units will operate at high occupancy and will operate with a positive financial margin. The rehabilitation unit will adopt approximately the same charge structure as the program at TriStar Southern Hills Medical Center, its sister facility in south Davidson County. Together, the two units will require approximately 35 new FTE's.

B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.

B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 *et seq.)* INCLUDING SQUARE FOOTAGE, MAJOR AREAS, ROOM CONFIGURATION, ETC.

Physical Description

The project has two components--a new 8-bed acute rehabilitation unit; and a new 12-bed orthopedic care surgical unit. They will be created by renovating and converting third-floor space that is currently an underutilized 20-bed adult psychiatric unit. When the TriStar Summit Medical Center's 12-bed rehabilitation unit opens, TriStar Skyline Medical Center in northern Davidson County will de-license its 10 rehabilitation beds at its Madison Campus. As a result:

- Summit Medical Center's total 188-bed hospital bed license will not change.
- Davidson County's total acute care hospital bed complements will be reduced by 10 beds (the 10 de-licensed by TriStar Skyline).
- Davidson County's net increase in rehabilitation beds will be only 2 beds, or 1% of the total 202 beds currently approved for that county.

After CON approval of the project, Summit's remaining psychiatric patients will be transferred to the larger 100-bed adult psychiatric program at TriStar Skyline Medical Center Madison, which has ample bed capacity to serve those additional patients.

Rehabilitation Unit

The proposed T-shaped acute rehabilitation unit will occupy three adjacent wings on the third floor of Summit's bed tower. In two wings, the unit will have 12 private patient rooms (6 on each wing) with handicapped-accessible/ADA-compliant private bathrooms; an ADL (Activities of Daily Living) suite with a kitchen, bedroom, and bath; a Day/Dining Room with an outside patio (on the roof of the floor below); a Physical Therapy exercise room; a central nursing station; and other patient and staff support spaces. The adjoining third wing in the "T" design will have a speech therapy room, a

physician office with an exam room, a conference room and library, a patient salon, and the staff offices and lounge.

Orthopedic Unit

The fourth wing on the third floor will contain 8 private rooms for orthopedic surgery patients, each with a handicapped-accessible/ADA-compliant private bathroom, a nursing station, and an activity room.

Table Two: Summary of Construction	
	Total Square Feet
Area of New Construction	0
Area of Renovation (Both Units)	22,218 SF
Total Area of Construction	22,218 SF

Source: Corporate planning department.

Operational Schedule

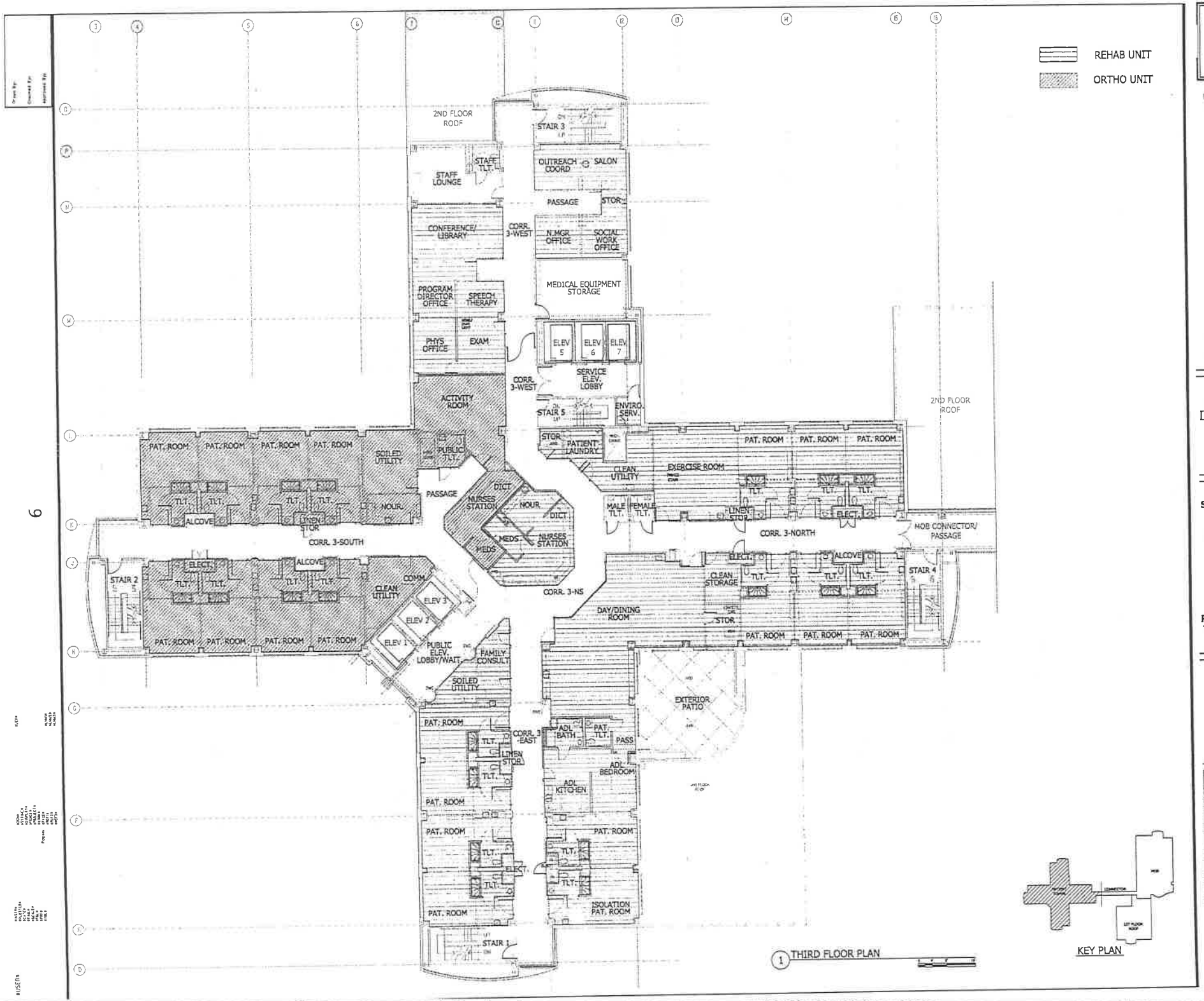
These are both inpatient acute care units that will provide medical care and supervision 24 hours daily, throughout the year. The applicant intends to open them on or before January 1, 2014. CY2014 will be their first full year of operation.

Cost and Funding

The project cost is estimated at approximately $5,000,000 ($4,933,576). This will be entirely funded by HCA, Inc., TriStar Summit Medical Center's ultimate parent company, through a cash transfer to TriStar Health System, HCA's regional office.

Medical Direction and Supervision for the Rehabilitation Program

To provide medical direction for the rehabilitation program, Summit intends to recruit a Board-certified physical medicine and rehabilitation specialist ("physiatrist"). Physiatrists provide medical direction for both of HCA's other rehabilitation programs in Davidson County (TriStar Skyline Medical Center and TriStar Southern Hills Medical Center).



G S & P

Design Services For The Built Environment

Atlanta
Birmingham
Cincinnati
Columbus
Dallas
Fort Lauderdale
Jackson
Jacksonville
Knoxville
Louisville
Memphis
Nashville
Richmond
Tampa

GRESHAM SMITH AND PARTNERS

CONTRACT DOCUMENTS

Summit Medical Center

Hermitage, TN

Third Floor Rehabilitation & Total Joint Unit Renovations

REVISION

No.	Date	Revision

FILE: BOONLB
PROJECT: 28 013.00
DATE: 09/28/15

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF $5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF $2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART...

Please see Attachment B.II.A. for this chart.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

The estimated $3,293,660 renovation construction cost for the project is approximately $149 PSF:

Table Three: Construction Cost PSF		
Construction Cost	**SF of Renovation**	**Construction Cost PSF**
$3,293,660	22,218	$148.24

The 2009-2011 hospital construction projects approved by the HSDA had the following costs per SF. This project's $149 PSF construction cost is very consistent with those ranges, being below the median for hospital renovation projects.

Hospital Construction Cost Per Square Foot
Applications Approved by the HSDA
Years: 2009 – 2011

	Renovated Construction	New Construction	Total Construction
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$273.69/sq ft	$324.00/sq ft	$301.74/sq ft

Source: Health Services and Development Agency, 2012

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.

Table Four: Proposed Changes in Assignment of Licensed Hospital Beds at Summit Medical Center		
Bed Assignment	**Current Assignment**	**Proposed Assignment (Change)**
General Medical-Surgical	110	118 (+8)
Critical Care	24	24
NICU	10	10
Obstetrics	24	24
Psychiatric	20	0 (-20)
Rehabilitation	0	12 (+12)
Total Licensed Complement	188	188

Note: Simultaneous with the 12-bed increase at this facility, an affiliated HCA hospital in the same county will reduce its total licensed complement by 10 rehabilitation beds.

The historic and projected utilization and occupancies for all categories of beds are projected in Attachment Sixteen, Section C(I)6, p. 42 of the application.

The reason for reallocating 12 psychiatric beds to a new rehabilitation unit is that residents of Summit's service area--eastern Davidson County and western Wilson County--need better access to acute inpatient rehabilitation care. Summit discharges a large number of patients who need rehabilitation. Almost all of this unit (10 of its 12 beds) will be a relocation of rehabilitation beds already licensed to Summit's parent organization in the same county—moving from a location where they are not being used, to a location where they are needed. The reason for reallocating 8 psychiatric beds to a new orthopedic unit is to provide needed surgical bed capacity. The surgical beds at Summit (all on its 5th floor) are very highly occupied, as are all the medical-surgical beds. More capacity is needed. See the discussions in Sections B.II.C. and C(II)4 below.

The project will require discontinuing Summit's adult psychiatric program, a 20-bed unit with only 59% occupancy in CY2012. However, Summit's sister hospital in north Davidson County, TriStar Skyline Medical Center, will integrate those patients into its much larger program, so that accessibility to care, and quality of care, will not be adversely affected. Skyline's beds are not yet optimally utilized and this addition of census will increase the efficiency of its utilization.

B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION):

1. **ADULT PSYCHIATRIC SERVICES**
2. **ALCOHOL AND DRUG TREATMENT ADOLESCENTS >28 DAYS**
3. **BIRTHING CENTER**
4. **BURN UNITS**
5. **CARDIAC CATHETERIZATION SERVICES**
6. **CHILD AND ADOLESCENT PSYCHIATRIC SERVICES**
7. **EXTRACORPOREAL LITHOTRIPSY**
8. **HOME HEALTH SERVICES**
9. **HOSPICE SERVICES**
10. **RESIDENTIAL HOSPICE**
11. **ICF/MR SERVICES**
12. **LONG TERM CARE SERVICES**
13. **MAGNETIC RESONANCE IMAGING (MRI)**
14. **MENTAL HEALTH RESIDENTIAL TREATMENT**
15. **NEONATAL INTENSIVE CARE UNIT**
16. **NON-RESIDENTIAL METHADONE TREATMENT CENTERS**
17. **OPEN HEART SURGERY**
18. **POSITIVE EMISSION TOMOGRAPHY**
19. **RADIATION THERAPY/LINEAR ACCELERATOR**
20. **REHABILITATION SERVICES**
21. **SWING BEDS**

1. Need for the Rehabilitation Program

Summit Medical Center has proposed this in-house acute rehabilitation service for several reasons. First, it is good for patients at this facility. Patients who have undergone amputation, stroke, burns, major traumas, bilateral (two at a time) joint replacements, shoulder and back surgery, or other events, or who are treated for serious arthritic or neurological issues, and many other conditions, all benefit from having access to acute inpatient rehabilitation immediately upon discharge from their initial hospital stay. It is efficient to be able to receive this kind of care on the same campus that they chose for their initial hospitalization. Getting all needed care at the facility of their choice is important to hospital patients.

Second, it is especially appropriate on this community hospital campus, at this time. In CY2011, Summit opened a major Emergency Department expansion and became one of Tennessee's 18 Joint Commission-designated Primary Stroke Centers. This distinction requires rigorous adherence to performance measurement criteria,

clinical practice guidelines, (AHA; American Stroke Association) and quality assurance standards. It requires daily, 24-hour availability of neurologists and neurosurgeons and a specialized inpatient stroke unit. As a Primary Stroke Center, Summit also conducts outreach efforts with other hospitals in the region to improve stroke intervention care.

The goal of the Primary Stroke Center program is to improve patient outcomes for victims of stroke. An acute inpatient rehabilitation program, following the acute stroke unit phase, is an important component in the continuum of care needed by most stroke patients. Having that under central clinical management assures more efficient and effective patient care planning from the time of symptom onset, to the time of discharge to the home. It is the best way for caregivers to have confidential, comprehensive, and accurate patient information, and to act on it appropriately, without having to coordinate care with other providers. Having a rehabilitation unit on site allows for easier continuity of care and consultation, for the physicians (e.g., neurologists) who manage the acute care phase.

Third, The new service will be well utilized at Summit. As mentioned above, during CY2011 Summit opened a major Emergency Department expansion, and became a Certified Stroke Center. As shown in Table Five below, Emergency Room visits increased almost 12% from CY 2011 to CY2012; and inpatient admissions coming through the Emergency Department increased almost 17%. As a result, Summit's medical-surgical beds in CY2012 exceeded 83% occupancy, and its discharges to inpatient acute rehabilitation programs at other facilities jumped almost 11%.

Table Five: Impact of Stroke Center and Expanded Emergency Room (ED) at Summit Medical Center CY2011 to CY2012

	Visits to the ED	IP Admissions Through ED	Discharges to Acute Rehab Programs
2011	47,065	6,753	176
2012	52,670	7,894	195
Change	+11.9%	+16.9%	+10.8%

Source: Hospital management.

Fourth, distribution of this service to suburban locations such as Summit Medical Center is a trend favored by patients and their families. Patients in Nashville have shown

a desire to utilize acute rehabilitation not just in tertiary downtown hospitals, but also in suburban hospitals closer to where they and their support groups live, and where they often receive hospital care. Table Six below illustrates that there has been a significant shift of rehabilitation admissions recently, from downtown centers to suburban locations. From 2008 to 2011, downtown rehabilitation admissions shrank by 15% while suburban rehabilitation admissions increased 56%. The suburban market share increased from 20% in 2008 to 32% in 2011, while the central Davidson County share decreased from 80% to 68% in that period. And during this, the total days of rehabilitation provided in Davidson County has remained stable. This has been an orderly redistribution of resources.

Table Six: Movement of Rehabilitation Patient Days in Davidson County CY2008-CY2011

Location	CY 2008	CY 2011	Change '08-'11
Central County	33,199 (80%)	28,221 (68%)	-15%
Suburban County Areas	8,329 (20%)	13,071 (32%)	+56%
Totals	41,528	41,292	

Source: Joint Annual Reports, 2008-2011. Central providers were Vanderbilt Stallworth, Baptist, and Nashville Rehabilitation Hospital (closed). Suburban providers were Skyline and Southern Hills Medical Centers. See Table Thirteen-B for detailed data.

Fifth, there is a need to correct a disparity of resources within greater Nashville. Summit's populous service area in far eastern Davidson County and nearby Wilson County is the only suburban area with a local hospital that does not offer inpatient acute rehabilitation care. Certificates of Need for this service have been granted to the suburban hospitals north, south, and west (Dickson) of Nashville. The eastern side of this large county needs a comparable service option.

Sixth, this project will not have major adverse impacts on other providers of rehabilitation care in either Davidson or Wilson Counties.

With respect to hospitals, the beds actually available in Davidson County in CY2011 operated at approximately 72% utilization--which is financially sound, and is consistent with the 75% occupancy that the Guidelines for Growth recommend for programs up to 30 beds.

SUPPLEMENTAL

Summit Medical Center CN1304-011 (Rehabilitation Service)
Data Utilized in Table Six, p. 14

Table Six Detail--Movement of Rehabilitation Patient Days (PD) Davidson County CY2008-CY2011					
	2008 PD	% of Tot PD	2011 PD	% of Tot PD	% Change 2008-2011
Central Facilities					
Baptist	6,135		6,041		
VU Stallworth	22,233		22,180		
Nashv. Rehab. Hosp.	4,831		0		
Central, Subtotal	33,199	80%	28,221	68%	- 15%
Suburban Facilities					
Skyline	8,329		11,306		
So. Hills	0		1,765		
Suburban, Subtotal	8,329	20%	13,071	32%	+56%
Davidson Co. Total	41,528		41,292		- 0.6%

Source: Joint Annual Reports of Hospitals, 2011, from Table Thirteen-B, CON application.

With respect to impact on nursing homes, this project should not significantly affect those currently receiving referrals from Summit Medical Center. Nursing homes typically provide less intense rehabilitation than hospitals offer, due to lower reimbursement in the nursing home setting. Summit's discharged patients not requiring hospital-level intensity of rehabilitation (3 hours or more per day) will continue to be referred to nursing home programs. With only 12 beds, the unit intends to serve patients who require more intensive rehabilitation than nursing homes would provide. If they are denied access to this care at Summit, such patients will seek admission to a hospital program elsewhere, not to a nursing home program.

Summit has been working, and will continue to work, with area nursing homes to ensure that patients are discharged to the level of care that is most clinically appropriate and cost-effective for their needs. Because of this cooperation, this application has now received several significant letters of support from area nursing home providers.

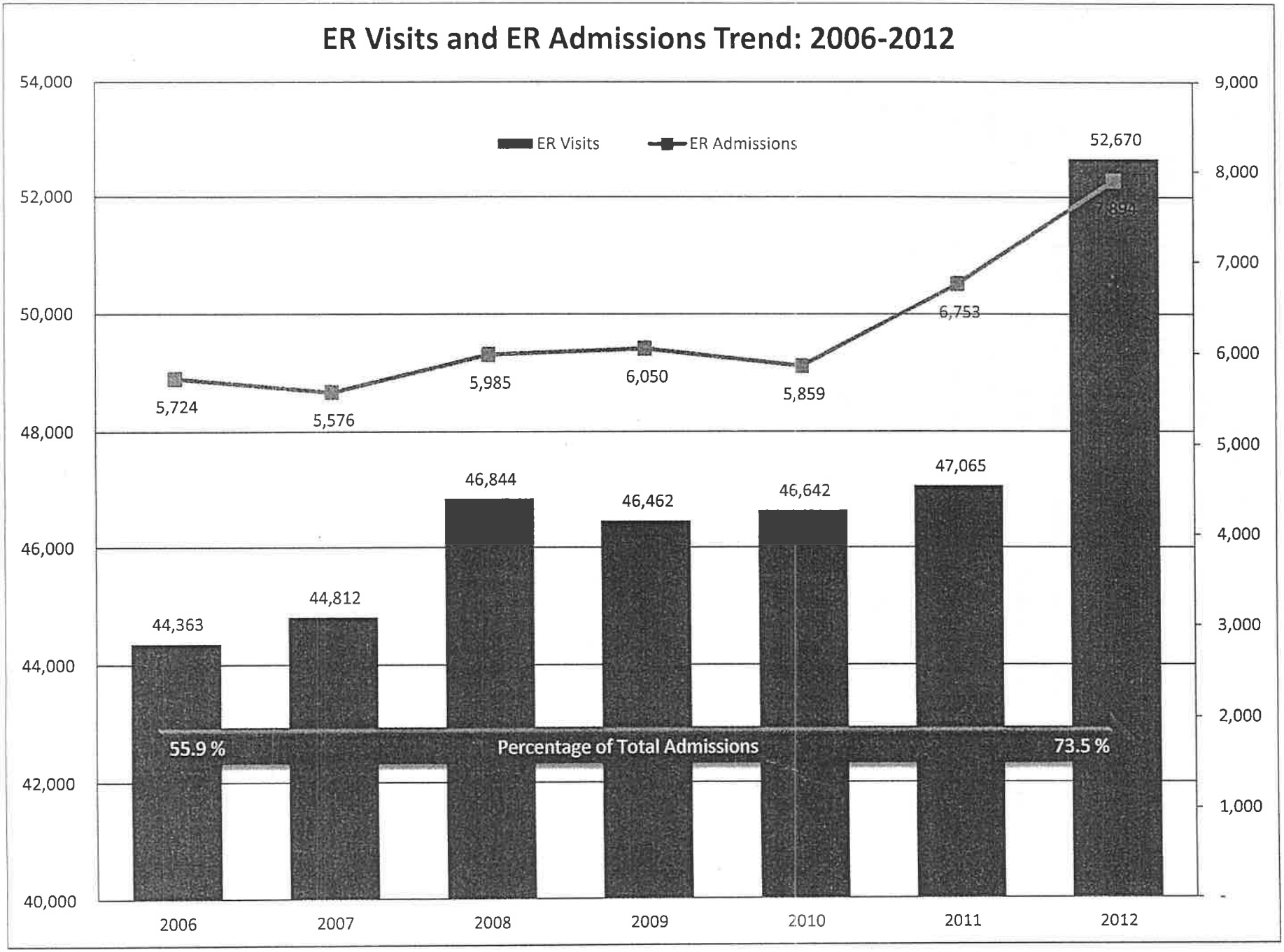
2. Need to Reassign Beds to an Orthopedic Unit

TriStar Summit Medical Center's occupancies on its licensed surgical beds, and total medical-surgical beds, is very high and rising. The fifth floor surgical unit, which is multidisciplinary, was at 78% occupancy on weekdays in CY2012, which are the peak days for elective surgeries such as total joint replacements. On 23% of those days, the surgical beds had higher than 90% occupancy, calculated by the standard method using midnight census. Mid-day census in the surgical unit is even higher, due to pending discharges that have not yet occurred that day. Note that there were many days when more than 100% of capacity was exceeded--which means that there were patients admitted to the surgical unit, who had to be held in Critical Care beds, the Recovery Room, or in ED stations that day, waiting for a surgical bed to become available.

Nor is it possible to expand the surgical beds at the expense of medical beds. The medical-surgical beds as a group exceeded 90% and even 100% on many weekday peaks.

By moving the orthopedic patients into a specialized unit on the third floor, Summit can relieve occupancy pressures on the nursing staff on the fifth floor, and can provide 4.5 to 5 orthopedic patients a day with care that is focused exclusively on their special needs. This should improve care for all the surgical patients on those floors.

The unit is also important as Summit moves toward Joint Commission certification as a Total Joint Center of Excellence. It has had an active Total Joint Committee working toward that end for several years, focusing on Performance Improvement, Quality Improvement, Physician Collaboration, Community Education, and Patient Satisfaction processes. The certification will be requested in the Fall of CY2013. The specialized orthopedic unit is an important part of establishing the levels of excellence required for joint replacement programs. It also fits well into the new Rehabilitation program on the same floor.


ER Visits and ER Admissions Trend: 2006-2012
ER Visits
ER Admissions
54,000
52,000
50,000
48,000
46,000
44,000
42,000
40,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
5,724
5,576
5,985
6,050
5,859
6,753
7,894
44,363
44,812
46,844
46,462
46,642
47,065
52,670
55.9 %
Percentage of Total Admissions
73.5 %
2006
2007
2008
2009
2010
2011
2012

B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.

Not applicable. The project does neither of those things.

B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF $1.5 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:

1. For fixed site major medical equipment (not replacing existing equipment):
- **a. Describe the new equipment, including:**
  1. **Total Cost (As defined by Agency Rule);**
  2. **Expected Useful Life;**
  3. **List of clinical applications to be provided; and**
  4. **Documentation of FDA approval.**
- **b. Provide current and proposed schedule of operations.**

2. For mobile major medical equipment:
- **a. List all sites that will be served;**
- **b. Provide current and/or proposed schedule of operations;**
- **c. Provide the lease or contract cost;**
- **d. Provide the fair market value of the equipment; and**
- **e. List the owner for the equipment.**

3. Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Not applicable. There is no major medical equipment proposed in this project.

B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:
1. **SIZE OF SITE (IN ACRES);**
2. **LOCATION OF STRUCTURE ON THE SITE;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.**

PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.

See Attachment B.III.A.

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

Summit Medical Center is located in Hermitage, on the far eastern edge of Davidson County near the Wilson County line. The hospital is on the west side of Old Hickory Boulevard / Highway 45, approximately one mile north of Exit 221 from I-40, and is visible from that exit. Summit serves patients primarily from eastern Davidson County and western Wilson County. Interstate I-40 and U.S. Highway 70, which run east and west between Nashville and Lebanon, are the service area's principal east-west roadways; Old Hickory Boulevard is one of the service area's major roadways running north-south by the Summit campus.

Summit is very accessible to western Wilson County, as well as to eastern Davidson County between Old Hickory Lake (the Cumberland River) and the areas west, north, and east of Percy Priest Lake. The rapidly growing Mt. Juliet community is the fastest growing sector of western Wilson County; and Mt. Juliet is much closer to Summit Medical Center (6.9 miles; 15 minutes) than it is to McFarland Hospital, which has Wilson County's only acute rehabilitation unit (17.3 miles; 22 minutes).

Table Seven: Mileage and Drive Times Between Summit Medical Center and Acute Rehabilitation Providers and Communities In the Primary Service Area

Acute IP Rehabilitation Provider	County	Distance (Mileage)	Drive Time (Minutes)
1. Baptist Hospital, Nashville	Davidson (Central)	13.1 mi.	18 min.
2. Stallworth Rehabilitation Hospital, Nashville	Davidson (Central)	14.9 mi.	19 min.
3. Nashville Rehabilitation Hospital (closed; license in abeyance)	Davidson (Central)	13.6 mi.	17 min.
4. Southern Hills Medical Center, Nashville	Davidson (South)	13.7 mi.	17 min.
5. Skyline Medical Center, Nashville	Davidson (North)	16.7 mi.	20 min.
6. City of Mt. Juliet	Wilson	6.9 mi.	15 min.
7. McFarland Hospital, Lebanon, Wilson County	Wilson	21.5 mi.	27 min.

Source: Google Maps, March 2013.

B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.

See attachment B.IV.

IV. FOR A HOME CARE ORGANIZATION, IDENTIFY

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

C(I) NEED

C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.

A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.

B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).

Project-Specific Review Criteria: Comprehensive IP Rehabilitation Services

1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.

2. The need shall be based upon the current year's population and projected four years forward.

Summit's primary service area counties are Davidson and Wilson Counties. Their combined CY2017 population will be 745,134 persons. At 10 beds per 100,000 persons, criteria #1 and #2 above identify a need for 74.5 beds for that population--more specifically, 62.2 in Davidson County and 12.3 in Wilson County.

However, it would not be rational to apply those criteria to this particular service area. Rehabilitation beds located in tertiary acute care referral areas such as Davidson County are regional, multi-county resources. The THA database indicates that in CY2011, only 47.5% of rehabilitation patients in Davidson and Wilson County programs were residents of Davidson and Wilson Counties. More than half of the beds used in those two counties were occupied by residents of other counties. Consider that in CY2011, the rehabilitation programs in these counties provided 44,086 actual days of rehabilitation care. At a very high standard of 80% occupancy (very full for mostly small units in peak periods) those days required 151 rehabilitation beds--twice what the guideline would project. (44,086 actual rehabilitation days / 365 / 80% = 151). And this

was two years before the Summit unit proposes to open. With an increasing population, there should be an even higher bed need in the future.

At present, there are 202 approved rehabilitation beds in both Davidson and Wilson counties. Of these, 41 are older beds that are not open and are not likely to re-open for this type of care. Only 161 beds are actually available. All approved beds have been implemented (but 41 have also closed in the past few years).

If all 202 rehabilitation beds are considered, this project will add only 2 beds—less than one per cent—to the service area total. The other 10 beds in this project are not additional beds: they are only relocated beds, within the same county.

3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.

Approximately 82% of Summit's admissions come from Davidson and Wilson counties; and the majority of Summit's rehabilitation unit admissions will come from Summit discharges. So these counties are an appropriate primary service area.

4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.

The project complies, having 12 beds.

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.

Not applicable.

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:

20-30 bed unit	**75%**
31-50 bed unit/facility	**80%**
51+-bed unit/facility	**85%**

This is a de minimus, insignificant addition of rehabilitation beds (2 beds or 1% of service area total rehabilitation beds); 10 of the proposed beds are merely being relocated from an affiliated hospital within Davidson County.

The term "existing units or facilities" should be applied to include only those that are operational or likely to be operational in the foreseeable future.

There are seven total acute rehabilitation units licensed for this service; but two are older units that have been closed for some time. In the applicant's opinion, neither is likely to re-open. This leaves five providers, whose reported 2011 occupancies are shown in Table Eight-A below. Below that, Table Eight-B shows 2012 occupancies for those who have filed Joint Annual Reports, or which are HCA hospitals whose 2012 data are available to the applicant.

Table Eight-A: CY2011Occupancies of Service Area Rehabilitation Providers	
Provider / December 2011 Beds	**CY2011 Occupancy**
Baptist Hospital / 24 beds	69.0%
VU Stallworth Rehab'n Hospital / 80 beds	76.0%
Skyline Medical Center / 41 beds	75.5%
Southern Hills Medical Center / 12 beds	69.2%
McFarland Hospital / 26 beds (Wilson Co.)	29.4%

Source: Joint Annual Report data from Table Eleven, Section C.(I).5 of this application.
Note: Southern Hills had rehabilitation beds available for only June-December and the occupancy above is based on 214 calendar days.

Table Eight-B: CY2012 Provisional Occupancies of Service Area Rehabilitation Providers (Not All Have Yet Reported)	
Provider / December 2012 Beds	**CY2012 Occupancy**
Baptist Hospital / 24 beds	78.3%
VU Stallworth Rehab'n Hospital / 80 beds	not yet reported
Skyline Medical Center / 41 beds	71.9%
Southern Hills Medical Center / 12 beds	69.5%
McFarland Hospital / 26 beds (Wilson Co.)	not yet reported

Source: Joint Annual Report data from Table Twelve, Section C.(I).5 of this application.
Note: Southern Hills had 12 beds during 2012 and opened 4 more in February 2013.

Although service area providers are not yet at the target occupancies of the criterion, nonetheless those located in Davidson County are efficiently utilized--at 72% overall, according to the most recent 2011 Joint Annual Reports. See Table Thirteen in this application, section C.(I).5 below.

HealthSouth's recently approved application to build a Vanderbilt-led rehabilitation hospital in Williamson County stated that Stallworth in central Davidson

County can not achieve much higher occupancy than its current level, because of its semiprivate rooms, which require gender separation that often prevents a second admission to a semi-private room. Stallworth has recently declined a number of Summit's requests for admissions to a rehabilitation bed.

Southern Hills' unit has grown in utilization so rapidly that the HSDA recently approved it to add four more rehabilitation beds (by conversion) regardless of the rehabilitation bed need criteria in the Guidelines.

Skyline's rehabilitation program has also grown rapidly, and will continue to grow, because of their neurosciences programs (stroke; neurosurgery; spinal surgery).

Only the UMC McFarland facility in Lebanon, almost a half-hour drive from Summit, has persistently low occupancy on its rehabilitation beds. Once a general hospital, and now a psychiatric and rehabilitation facility, McFarland many years ago was approved to designate a much larger rehabilitation unit (26 beds) than it has ever been able to utilize. Its low utilization is not a good reason to deny a needed service in Davidson County that serves a largely different patient population. Summit serves Davidson and western Wilson County residents who are used to obtaining hospital care in Davidson County, rather than in a rural area. For these patients, driving away from Nashville to rural Lebanon is not a reasonable option. Davidson County is not even in McFarland's primary service area because in 2011 only 3% of McFarland's total admissions (both psychiatric and rehabilitation) came from Davidson County. See McFaland's 2011 Joint Annual Report.

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board-certified physiatrist.

Complies. Staffing requirements and resources for the project are set forth in response C.(III)3, p. 64 below. The staffing conforms to licensure requirements. Summit will seek a board-certified physiatrist as medical director of the rehabilitation unit. Physiatrists direct the rehabilitation programs at Skyline and Southern Hills, its sister hospitals in Nashville.

SUPPLEMENTAL

Project-Specific Review Criteria--Acute Care Bed Services

Not applicable. This project does not add acute care beds to its service area. It decreases the area's acute care beds by 10 beds, or 1.1% of the 918-bed "surplus" projected by the Department of Health for the CY2013-CY2017 time period. However, some responses to the acute care bed guidelines are provided below to provide a better context for the project.

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year...(guidelines detail the steps of the bed need projection methodology; see pp. 15-16 of Guidelines for Growth.)

The Tennessee Department of Health's most recently issued bed need projection (for 2013-2017) is provided following this response. It indicates a surplus of 918 acute care hospital beds in the project's service area, Davidson and Wilson Counties. It indicates a total licensed bed complement of 3,930 beds in the project's service area.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80% for the most recent joint annual report. Occupancy should be based on the number of licensed beds rather than on staffed beds.

b) All outstanding new acute care bed CON projects in the proposed service area are licensed.

c) The Health Facilities Agency may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

Not applicable. The project does not seek to increase area beds; it seeks to decrease them:

Table Nine: Minimal Impact of Two Additional Beds On Service Area Hospital Bed Complements

	Licensed Beds	Bed Surplus 2017	Proposed New Beds	% of Licensed Beds	% of Bed Surplus
Davidson Co.	3,685	795	-10	- .27 of 1%	-1.3%
Wilson Co.	245	75	none	0	0
Service Area	3,930	870	-10	- .25 of 1%	-1.1%

Source: TN Department of Health Hospital Bed Need Projection, 2013-2017

ACUTE-CARE BED NEED PROJECTIONS FOR 2013 AND 2017

COUNTY	2011		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2011 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2011	2013	2017	ADC-2013	NEED 2013	ADC-2017	NEED 2017	LICENSED	STAFFED	LICENSED	STAFFED
Anderson	50,722	139	174	89,388	90,048	91,394	140	175	142	178	301	255	-123	-77
Beford	8,782	24	36	20,193	20,842	22,142	25	36	26	38	60	60	-22	-22
Benton	2,162	6	12	2,202	2,215	2,237	6	12	6	12	25	12	-13	0
Bledsoe	2,473	7	13	2,140	2,171	2,225	7	13	7	13	25	25	-12	-12
Blount	54,489	149	187	92,934	94,841	98,481	152	190	158	198	304	238	-106	-40
Bradley	39,262	108	135	79,566	80,894	83,513	109	137	113	141	351	207	-210	-66
Campbell	20,589	56	74	19,536	19,696	19,988	57	74	58	75	120	97	-45	-22
Cannon	7,467	21	31	4,638	4,724	4,891	21	32	22	32	60	50	-28	-18
Carroll	8,543	23	35	16,893	17,017	17,272	24	35	24	35	115	67	-80	-32
Carter	15,615	43	58	30,906	31,122	31,527	43	58	44	59	121	79	-62	-20
Chaatham	1,550	4	9	1,369	1,404	1,471	4	9	5	9	12	12	-3	-3
Chester	.	.	.	.	.	.	.	.	.	.	.	.		
Claiborne	8,504	23	35	14,433	14,618	14,957	24	35	24	36	85	39	-49	-3
Clay	4,671	13	21	5,138	5,174	5,251	13	21	13	22	36	34	-14	-12
Cocke	5,985	16	26	12,945	13,120	13,440	17	26	17	27	74	38	-47	-11
Coffee	32,764	90	112	59,632	60,804	63,097	92	114	95	119	214	154	-95	-35
Crockett	.	.	.	.	.	.	.	.	.	.	.	.		
Cumberland	25,428	70	89	44,368	45,142	46,463	71	91	73	93	189	133	-96	-40
Davidson	797,591	2,185	2,732	1,388,060	1,414,267	1,468,698	2,226	2,783	2,312	2,890	3,685	2,998	-795	-108
Decatur	2,756	8	14	4,402	4,414	4,436	8	14	8	14	40	27	-26	-13
Dekalb	4,616	13	21	8,542	8,682	8,961	13	21	13	22	71	56	-49	-34
Dickson	20,126	55	72	33,648	34,345	35,717	56	74	58	76	157	122	-81	-46
Dyer	16,816	46	62	35,443	35,791	36,502	47	62	47	64	225	120	-161	-56
Fayette	1,141	3	7	3,184	3,269	3,427	3	7	3	8	46	10	-38	-2
Fentress	7,141	20	30	13,108	13,273	13,584	20	30	20	31	85	54	-54	-23
Franklin	23,423	64	83	34,411	34,874	35,782	65	84	67	86	152	110	-66	-24
Gibson	5,700	16	25	9,070	9,118	9,232	16	25	16	25	209	90	-184	-65
Giles	7,200	20	30	11,304	11,411	11,613	20	30	20	31	95	81	-64	-50
Grainger	.	.	.	.	.	.	.	.	.	.	.	.		
Greene	27,048	74	94	46,963	47,432	48,340	75	95	76	97	240	170	-143	-73
Grundy	.	.	.	.	.	.	.	.	.	.	.	.		
Hamblen	42,559	117	146	76,224	77,297	79,367	118	148	121	152	302	226	-150	-74
Hamilton	386,592	1,059	1,324	657,397	666,979	686,138	1,075	1,343	1,106	1,382	1,596	1,236	-214	146
Hancock	830	2	6	1,598	1,603	1,615	2	6	2	6	10	10	-4	-4
Hardeman	915	3	6	2,886	2,940	3,044	3	6	3	6	51	21	-45	-15
Hardin	7,167	20	30	14,966	15,104	15,363	20	30	20	31	58	49	-27	-18
Hawkins	5,144	14	23	12,665	12,855	13,217	14	23	15	24	50	46	-26	-22
Haywood	2,328	6	12	6,338	6,381	6,478	6	12	7	13	62	36	-49	-23
Henderson	3,034	8	15	6,910	7,006	7,195	8	15	9	15	45	45	-30	-30
Henry	16,661	46	61	27,507	27,754	28,211	46	62	47	63	142	101	-79	-38
Hickman	1,170	3	7	2,948	3,033	3,200	3	8	3	8	25	25	-17	-17
Houston	4,054	11	19	5,034	5,092	5,219	11	19	12	19	35	35	-16	-16
Humphreys	1,737	5	10	3,209	3,252	3,336	5	10	5	10	25	25	-15	-15
Jackson	.	.	.	.	.	.	.	.	.	.	.	.		
Jefferson	9,093	25	37	17,021	17,386	18,087	25	37	26	38	58	58	-20	-20
Johnson	43	0	1	204	206	210	0	1	0	1	2	2	-1	-1
Knox	450,085	1,233	1,541	770,195	781,766	804,214	1,252	1,565	1,288	1,609	2,167	1,758	-558	-149
Lake	.	.	.	.	.	.	.	.	.	.	.	.		
Lauderdale	3,128	9	15	4,616	4,700	4,862	9	16	9	16	25	25	-9	-9
Lawrence	10,589	29	42	19,274	19,530	20,046	29	42	30	43	99	80	-56	-37
Lewis	.	.	.	.	.	.	.	.	.	.	.	.		
Lincoln	7,837	22	32	17,244	17,459	17,873	22	33	22	33	59	59	-26	-26
Loudon	6,543	18	28	12,014	12,232	12,612	18	28	19	29	50	40	-21	-11
McMinn	16,886	46	62	34,325	34,885	35,959	47	63	49	65	190	111	-125	-46
McNairy	5,440	15	24	12,375	12,497	12,731	15	24	15	24	45	45	-21	-21

ACUTE-CARE BED NEED PROJECTIONS FOR 2013 AND 2017

COUNTY	2011		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2011 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2011	2013	2017	ADC-2013	NEED 2013	ADC-2017	NEED 2017	LICENSED	STAFFED	LICENSED	STAFFED
Macon	3,366	9	16	5,674	5,791	6,027	9	17	10	17	25	25	-8	-8
Madison	177,234	486	607	272,116	275,400	282,159	491	614	504	629	787	747	-158	-118
Marion	3,898	11	18	3,118	3,142	3,188	11	18	11	19	70	63	-51	-44
Marshall	884	2	6	2,245	2,292	2,389	2	6	3	6	25	12	-19	-6
Maury	46,215	127	158	103,836	105,818	109,813	129	161	134	167	255	206	-88	-39
Meigs	.	.	.	.	.	.	.	.	.	.	.	.		
Monroe	11,356	31	44	20,078	20,519	21,362	32	45	33	46	59	59	-13	-13
Montgomery	46,520	128	159	112,084	114,912	120,743	131	163	137	172	270	220	-98	-48
Moore	.	.	.	.	.	.	.	.	.	.	.	.		
Morgan	.	.	.	.	.	.	.	.	.	.	.	.		
Obion	10,179	28	40	21,510	21,611	21,821	28	40	28	41	173	85	-132	-44
Overton	17,266	47	63	21,350	21,593	22,059	48	64	49	65	114	82	-49	-17
Perry	6,677	18	28	5,480	5,528	5,626	18	28	19	29	53	39	-24	-10
Pickett	.	.	.	.	.	.	.	.	.	.	.	.		
Polk	0	0	0	.	.	.	.	.	.	.	25	25	-25	-25
Putnam	58,765	161	201	93,457	95,035	98,121	164	205	169	211	247	242	-36	-31
Rhea	4,058	11	19	8,347	8,474	8,720	11	19	12	20	25	25	-5	-5
Roane	7,404	20	31	14,542	14,671	14,918	20	31	21	31	105	36	-74	-5
Robertson	17,956	49	66	30,920	31,888	33,768	51	67	54	71	109	66	-38	5
Rutherford	82,917	227	284	207,877	214,741	228,278	235	293	249	312	387	387	-75	-75
Scott	1,589	4	9	4,006	4,079	4,219	4	9	5	10	25	14	-15	-4
Sequatchie	.	.	.	.	.	.	.	.	.	.	.	.		
Sevier	12,458	34	48	31,858	32,695	34,271	35	49	37	51	79	69	-28	-18
Shelby	952,572	2,610	3,262	1,431,067	1,449,312	1,487,483	2,643	3,304	2,713	3,391	4,081	3,117	-690	274
Smith	8,024	22	33	10,184	10,396	10,809	22	33	23	35	88	58	-53	-23
Stewart	.	.	.	.	.	.	.	.	.	.	.	.		
Sullivan	250,675	687	859	427,099	433,501	446,335	697	871	718	897	1,056	789	-159	108
Sumner	45,344	124	155	104,293	106,912	112,031	127	159	133	167	341	236	-174	-69
Tipton	5,041	14	22	13,358	13,707	14,403	14	23	15	24	100	44	-76	-20
Tousdale	2,255	6	12	2,754	2,804	2,916	6	12	7	13	25	21	-12	-8
Unicoi	4,601	13	21	6,392	6,408	6,436	13	21	13	21	48	10	-27	11
Union	.	.	.	.	.	.	.	.	.	.	.	.		
Van Buren	.	.	.	.	.	.	.	.	.	.	.	.		
Warren	13,658	37	52	23,286	23,674	24,452	38	52	39	54	125	50	-71	4
Washington	167,583	459	574	198,067	199,952	203,732	463	579	472	590	581	581	9	9
Wayne	2,100	6	11	4,996	5,051	5,153	6	12	6	12	80	32	-68	-20
Weakley	8,113	22	33	17,317	17,386	17,578	22	33	23	34	100	65	-66	-31
White	6,494	18	28	9,623	9,753	9,996	18	28	18	29	60	44	-31	-15
Williamson	33,032	91	113	95,194	98,713	105,881	94	117	101	126	185	185	-59	-59
Wilson	45,939	126	157	58,451	60,054	63,171	129	162	136	170	245	245	-75	-75

Source: Office of Health Statistics, Division of Policy, Planning and Assessment, Tennessee Department of Health. 10/29/12

Data from 2011 Final JAR-Hospitals Schedules F and G. Underlying Tennessee population estimates and projections (2008 Series) from Division of Health Statistics. Projections and estimates for other states are from U.S. Census Bureau, Population Division release data 4/21/2005.

27

50

The Framework for Tennessee's Comprehensive State Health Plan
Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans.
Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

This project will enable Summit Medical Center to broaden its continuum of care by adding a rehabilitation program that is appropriate for the only designated Stroke Center and emergency care resource on the eastern side of the county. The project has stimulated joint discussions and coordinated planning between this hospital and several area nursing homes which provide rehabilitation at lower levels than in acute care hospitals.

2. Access to Care

Every citizen should have reasonable access to health care.
Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

The application proposes that the HSDA continue to support the distribution of acute rehabilitation services to suburban communities surrounding Nashville, to improve public access time to acute rehabilitation care.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

This project is consistent with past CON decisions to distribute acute rehabilitation programs to suburban sectors of the Nashville area, without increasing total licensed

hospital beds. The public's need for this has been demonstrated by the rapid growth in utilization of such units, and by the operational closure of inpatient rehabilitation beds in central Davidson County. This is an improvement in access for suburban patients, accomplished in an efficient manner by re-assignment of existing bed units.

The component of the project that requires discontinuation of this hospital's underutilized adult psychiatric service also encourages the efficient use of available resources. Summit's patients in that unit will be transferred to the much larger and more comprehensive adult program at Skyline Medical Center, increasing the utilization of the latter facility to levels of higher efficiency. At the same time, the bed conversions at Summit will result in better utilization of the 20 reassigned beds than is the case in the pscychiatric program currently.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

TriStar hospitals such as Summit Medical Center pursue and maintain high quality standards in their services, as defined by best practices standards within HCA as well as by standards promulgated by State licensure.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

The project's rehabilitation program will provide a broadened clinical rotation for students in physical therapy programs of Tennessee educational institutions. Summit already participates in the training of therapists and this will be a major expansion of that role.

The project's orthopedic unit will support development of a Joint Commission-certified center of excellence in total joint replacement surgery, which can serve as an improved rotation site for health professionals at Summit.

C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.

As stated, this project continues to implement HCA TriStar's plan to distribute acute rehabilitation services to suburban locations closer to many patients' homes.

SUPPLEMENTAL

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

Summit Medical Center receives approximately 84% of its admissions from Davidson and Wilson Counties. On a sub-county level, Summit receives most of its admissions from eastern Davidson County and western Wilson County, for whom it is an important hospital resource. Because HCA TriStar's experience is that the great majority of its rehabilitation units' admissions are patients discharged from the hospital of which they are a part, it is logical to assume that Davidson and Wilson Counties will also be the primary service area for the proposed rehabilitation service. Table Ten below reflects that assumption; its percentages mirror the experience of the hospital in CY2011.

A service area map and a map showing the location of the service within the State of Tennessee are provided as Attachments C, Need--3 at the back of the application.

Table Ten: Projected Patient Origin
Summit Medical Center Acute Inpatient Rehabilitation Unit

PSA County	Percent of Total	Yr. 1 Admissions	Yr. 2 Admissions
Davidson	55.8%	151	158
Wilson	28.4%	77	81
PSA Subtotal	**84.2%**	**228**	**239**
Other Counties or States (<3% each)	15.8%	42	45
Total	100.0%	270	284

Source: Applicant's CY2011 Joint Annual Report; admissions from Projected Data Chart.

C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

Please refer to Table Eleven on the following page. The county-based primary service area is increasing in population. The State projects that the total population will increase by 3.2 % between 2013 and 2017, and that the elderly 65+ population will increase by 12.9%. This is similar to the projections for the State as a whole. The primary service area's income, poverty and TennCare profiles are not very different from the State average.

But within the primary service area, Wilson County has higher median income, a lower poverty rate, and a lower percentage of its residents enrolled in TennCare than does Davidson County.

Table Eleven: Demographic Characteristics of Primary Service Area Counties Summit Medical Center 2013-2017				
Demographic	Davidson County	Wilson County	PRIMARY SERVICE AREA	STATE OF TENNESSEE
Median Age-2010 US Census	33.9	39.3	36.6	38.0
Total Population-2013	605,923	116,150	722,073	6,361,070
Total Population-2017	622,476	122,658	745,134	6,575,165
Total Population-% Change 2013 to 2017	2.7%	5.6%	3.2%	3.4%
Age 65+ Population-2013	72,486	14,229	86,715	878,496
% of Total Population	12.0%	12.3%	12.0%	13.8%
Age 65+ Population-2017	81,389	16,548	97,937	987,074
% of Population	13.1%	13.5%	13.1%	15.0%
Age 65+ Population-% Change 2013-2017	12.3%	16.3%	12.9%	12.4%
Women Age 15-44 Population--2013	121,587	23,617	145,204	1,267,193
% of Population	20.1%	20.3%	20.1%	19.9%
Women Age 15-44 Population--2017	120,914	24,913	145,827	1,287,243
% of Population	19.4%	20.3%	19.6%	19.6%
Women Age 15-44 % Change 2013-2017	-0.6%	5.5%	-2.7%	1.6%
Median Household Income	$46,737	$50,579	$48,658	$43,989
TennCare Enrollees (10/12)	121,002	14,294	135,296	1,213,474
Percent of 2013 Population Enrolled in TennCare	20.0%	12.3%	18.7%	19.1%
Persons Below Poverty Level (2013)	107,248	9,873	117,121	1,075,021
Persons Below Poverty Level As % of Population (US Census)	17.7%	8.5%	16.2%	16.9%

Sources: TDH Population Projections, Feb. 2008; U.S. Census QuickFacts and FactFinder2; TennCare Bureau. PSA data is unweighted average or total of county data.
NR means not reported in U.S. Census source document.

C(I).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.

Like other services of Summit Medical Center, this proposed inpatient acute rehabilitation unit will be accessible to the above groups. It will accept both Medicare and TennCare patients. Like most other such units, the large majority of its services will be for elderly patients. But it will also serve some patients younger than 65, who require rehabilitation from stroke, amputation, bone and joint surgery, and other conditions.

C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.

The table below shows the acute inpatient rehabilitation providers in the two-county service area, and their drive times and distances from the project site (Summit).

Table Twelve: Mileage and Drive Times Between Summit Medical Center and Acute Rehabilitation Providers In the Primary Service Area

Acute IP Rehabilitation Provider and City	County	Distance (Mileage)	Drive Time (Minutes)
1. Baptist Hospital, Nashville	Davidson (Central)	13.1 mi.	18 min.
2. Stallworth Rehabilitation Hospital, Nashville	Davidson (Central)	14.9 mi.	19 min.
3. Nashville Rehabilitation Hospital (closed; license in abeyance)	Davidson (Central)	13.6 mi.	17 min.
4. Southern Hills Medical Center, Nashville	Davidson (South)	13.7 mi.	17 min.
5. Skyline Medical Center, Nashville	Davidson (North)	16.7 mi.	20 min.
6. McFarland Hospital, Lebanon	Wilson	21.5 mi.	27 min.

Source: Google Maps, March 2013..

Utilization of rehabilitation beds in this area has to take into account the significant numbers of licensed, existing rehabilitation beds in Davidson County that are not available to patients, due to serious facility licensure issues or due to lack of need at their original location. Table Thirteen-A below shows the number of total approved/existing rehabilitation beds in Davidson County and the number that are not operational, in CY2012 and CY2013.

C(I).6. PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE TWO (2) YEARS FOLLOWING COMPLETION OF THE PROJECT. ADDITIONALLY, PROVIDE THE DETAILS REGARDING THE METHODOLOGY USED TO PROJECT UTILIZATION. THE METHODOLOGY MUST INCLUDE DETAILED CALCULATIONS OR DOCUMENTATION FROM REFERRAL SOURCES, AND IDENTIFICATION OF ALL ASSUMPTIONS.

Summit Medical Center on Interstate 40 is the only hospital located in or near the populous and growing communities of eastern Davidson County and western Wilson County. Summit opened a major Emergency Department Expansion in July 2011, and received Accreditation as a Primary Stroke Care Center in November 2011. As a result of these and other service improvements, the hospital's discharges of patients with conditions requiring rehabilitation have soared upward.

Table Fourteen below shows the increase in Summit's discharges to acute rehabilitation programs at all locations, between 2011 and 2012.

Table Fourteen: Annual Discharges to Acute Rehabilitation Programs by Summit Medical Center

	CY2011	CY2012	Percent Increase
Discharges to Acute Rehabilitation Services	176	195	+10.8%

Source: Hospital records.

Utilization Projection for the Project

Medicare-approved acute rehabilitation units are now required to have 60% of their patient population classified in one of thirteen "Rehabilitation Impairment Categories", or "RIC's". The other 40% of a unit's patients may be other types of conditions that are deemed medically appropriate for rehabilitation. Failure to maintain the 60% standard will result in decertification by Medicare. Providers work very hard not to violate that objective. Summit's projected unit will be managed to have no less than 62% of its patients in the RIC categories at any time. The RIC group of conditions includes stroke, spinal cord injury, amputation, major multiple trauma, hip fracture, brain

injury, neurological disorders, burns, active rheumatoid arthritis, congenital deformity, systemic vasculidities, severe or advanced osteoarthritis, hip and knee replacements with patient obesity and BMI of 50+, and any patient 85 years of age or older.

It should be noted that more than a third of the patients in acute rehabilitation units are there for significant conditions other than the thirteen RIC conditions. An often-cited example is rehabilitation following shoulder surgery. So utilization for this unit was projected considering both RIC and non-RIC patients.

Table Fifteen below (the second following page) sets out the projection. It was made by projecting a hypothetical CY2012 admissions figure that would have been available to a Summit rehabilitation unit in 2012, and then projecting annual increases over the next two years.

Step 1: Summit identified in its past year's discharge base (11-1-11 through 10-31-12) the number of patients that met RIC criteria, and thus were eligible for an acute rehabilitation admission (242).

Step 2: Assuming that the RIC number would be 62% of total admissions, a non-RIC potential admissions number was calculated: Non-RIC = 38% of the total = 148.

Step 3: The RIC and non-RIC potential patients were added to estimate 390 potential admissions from Summit's own internal discharges that year

Steps 4-5: Summit then estimated that only 62% of the 390 potential patients were discharged to any hospital rehabilitation program. This was based on HCA experience locally with its own hospitals. It reflects many factors, including patient choice, payor willingness to cover rehabilitative care, the experience of case management personnel, etc. Application of the 62% factor reduced the potential Summit discharges to 242.

Steps 6-7: Using a weighted average of experience at HCA TriStar's Skyline and Southern Hills rehabilitation programs, Summit projected that a Summit program would have retained 81% of its 242 internal discharges, or 196 admissions that year, had the unit been open at that time.

Also at Step 7, Summit projected a 10% increase in available admissions by CY2014 (Year One of the proposed unit). This is a realistic assumption. The increase in the hospital's discharges to all acute rehabilitation programs was 10.8% greater in 2012 than in 2011. This would give Summit 216 internally generated admissions in Year One of the rehabilitation program.

Steps 8-9: HCA rehabilitation units in Nashville also receive approximately 20% of their total referrals from non-HCA hospitals. Applying this factor to the Summit program, results in 54 additional admissions, or a total of 270 admissions, In Year One (216 / 80% = 270). At an average length of stay of 13.5 days (HCA's experience in Nashville), the unit will achieve 83.3% occupancy in its first year of operation. Its total admissions were projected to increase 5.2% in Year Two, giving the unit 87.6% occupancy in Year Two.

Following Table Fifteen is Table Sixteen, Summit's historical and projected utilization of its beds by service. A page of notes after Table Sixteen discusses its projections.

Table Fifteen: Projected Utilization of Rehabilitation Unit Summit Medical Center (SMC) CY2013-CY2014			
	11/1/1 through 10/31/12	**Year 1 CY2014**	**Year 2 CY2015**
1. Summit Medical Center (SMC) Discharges of RIC Patients	242	--	--
2. Other SMC Non-RIC Discharges Appropriate for Rehabilitation	148	--	--
3. Total Potential SMC Discharges of Patients Appropriate for Rehabilitation	390	--	--
4. Percent of Total That Will be Discharged to Rehabilitation	62%	--	--
5. Actual SMC Internal Discharges to Rehabilitation at Any Facility	242	--	--
6. Percent of SMC's Discharges to Rehabilitation Retained by SMC	81%	--	--
7. SMC Internal Discharges to SMC Rehabilitation (Annual Change)	196	216 (+10%)	--
8. Referrals to SMC Rehabilitation From Other Facilities (20% of Total)	--	54	
9. Total SMC Admissions	--	270	284 (+5.2%)
10. ALOS (Average Length of Stay)	--	13.5 days	13.5 days
11. Patient Days	--	3,645	3,834
12. ADC (Average Daily Census)	--	10.0	10.5
13. Rehabilitation Bed Occupancy	--	83.3%	87.6%

Table Sixteen: Summit Medical Center
Utilization of Licensed Beds, CY 2010 - CY 2012
Projected Utilization of Licensed Beds, CY 2013-2015

	Actual 2010	Actual 2011	Actual 2012	Projected 2013	Rehabilitation Year One Projected 2014	Rehabilitation Year Two Projected 2015
Total Beds	188	188	188	188	188	188
Admissions	9,850	9,984	10,737	10,989	10,890	11,198
Patient Days	39,921	38,552	42,673	43,760	44,175	45,504
ALOS on Admissions	4	3.9	3.97	3.98	4.06	4.06
ADC on Admissions	109.4	105.6	116.6	119.9	121.0	124.7
Occupancy on Admissions	58.2%	56.2%	62.0%	63.8%	64.4%	66.3%
23-Hour Observation Days	5,207	4,676	4,183	4,298	4,417	4,539
Total Bed Days	48,710	46,367	46,825	48,059	48,592	50,043
Total ADC	133.5	127.0	128.3	131.7	133.1	137.1
Total Occupancy	71.0%	67.6%	68.2%	70.0%	70.8%	72.9%
Medical-Surgical Beds	110	110	110	110	118	118
Admissions	6,671	6,713	7,541	7,767	8,000	8,240
Patient Days	30,099	27,134	29,794	30,688	31,608	32,557
ALOS on Admissions	4.5	4.0	4.0	4.0	4.0	4.0
ADC on Admissions	82.5	74.3	81.6	84.1	86.6	89.2
Occupancy on Admissions	75.0%	67.6%	74.2%	76.4%	73.4%	75.6%
23-Hour Observation Days	4,670	4,427	3,673	3,783	3,897	4,014
Total Bed Days	34,769	31,561	33,467	34,471	35,505	36,570
Total ADC	95.3	86.5	91.7	94.4	97.3	100.2
Total Occupancy	86.6%	78.6%	83.4%	85.9%	82.4%	84.9%
Critical & Intermediate Care Beds	24	24	24	24	24	24
Admissions	1,082	1,163	1,284	1,323	1,362	1,403
Patient Days	5,105	5,601	4,804	4,948	5,097	5,249
ALOS on Admissions	4.7	4.8	3.7	3.7	3.7	3.7
ADC on Admissions	14.0	15.3	13.2	13.6	14.0	14.4
Occupancy on Admissions	58.3%	63.9%	54.8%	56.5%	58.2%	59.9%
23-Hour Observation Days	0	0	0	0	0	0
Total Bed Days	5,105	5,601	4,804	4,948	5,097	5,249
Total ADC	14.0	15.3	13.2	13.6	14.0	14.4
Total Occupancy	58.3%	63.9%	54.8%	56.5%	58.2%	59.9%
NICU Beds	10	10	10	10	10	10
Admissions	69	62	49	49	50	50
Patient Days	825	814	750	758	765	773
ALOS on Admissions	12.0	13.1	15.3	15.3	15.3	15.3
ADC on Admissions	2.3	2.2	2.1	2.1	2.1	2.1
Occupancy on Admissions	22.6%	22.3%	20.5%	20.8%	21.0%	21.2%
23-Hour Observation Days	0	0	0	0	0	0
Total Bed Days	825	814	750	758	765	773
Total ADC	2.3	2.2	2.1	2.1	2.1	2.1
Total Occupancy	22.6%	22.3%	20.5%	20.8%	21.0%	21.2%
Rehabilitation Beds	0	0	0	0	12	12
Admissions	0	0	0	0	270	284
Patient Days	0	0	0	0	3,645	3,834
ALOS on Admissions	0.0	0.0	0.0	0.0	13.5	13.5
ADC on Admissions	0.0	0.0	0.0	0.0	10.0	10.5
Occupancy on Admissions	0.0%	0.0%	0.0%	0.0%	83.2%	87.5%
23-Hour Observation Days	0	0	0	0	0	0
Total Bed Days	0	0	0	0	3,645	3,834
Total ADC	0.0	0.0	0.0	0.0	10.0	10.5
Total Occupancy	0.0%	0.0%	0.0%	0.0%	83.2%	87.5%
Obstetrical Beds	24	24	24	24	24	24
Admissions	1,395	1,232	1,184	1,196	1,208	1,220
Patient Days	3,582	3,139	3,000	3,030	3,060	3,091
ALOS on Admissions	2.6	2.5	2.5	2.5	2.5	2.5
ADC on Admissions	9.8	8.6	8.2	8.3	8.4	8.5
Occupancy on Admissions	40.9%	35.8%	34.2%	34.6%	34.9%	35.3%
23-Hour Observation Days	537	249	510	515	520	525
Total Bed Days	4,119	3,388	3,510	3,545	3,581	3,616
Total ADC	11.3	9.3	9.6	9.7	9.8	9.9
Total Occupancy	47.0%	38.7%	40.1%	40.5%	40.9%	41.3%
Pediatric Beds	0	0	0	0	0	0
Admissions	0	0	0	0	0	0
Patient Days	0	0	0	0	0	0
ALOS on Admissions	0.0	0.0	0.0	0.0	0.0	0.0
ADC on Admissions	0.0	0.0	0.0	0.0	0.0	0.0
Occupancy on Admissions	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23-Hour Observation Days	0	0	0	0	0	0
Total Bed Days	0	0	0	0	0	0
Total ADC	0.0	0.0	0.0	0.0	0.0	0.0
Total Occupancy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Psychiatric Beds	20	20	20	20	0	0
Admissions	633	814	647	653	0	0
Patient Days	3,892	5,003	4,294	4,337	0	0
ALOS on Admissions	6.1	6.1	6.6	6.6	0.0	0.0
ADC on Admissions	10.7	13.7	11.8	11.9	0.0	0.0
Occupancy on Admissions	53.3%	68.5%	58.8%	59.4%	0.0%	0.0%
23-Hour Observation Days	0	0	0	0	0	0
Total Bed Days	3,892	5,003	4,294	4,337	0	0
Total ADC	10.7	13.7	11.8	11.9	0.0	0.0
Total Occupancy	53.3%	68.5%	58.8%	59.4%	0.0%	0.0%

Source: Hospital Management

NOTES TO TABLE SIXTEEN

1. Medical-surgical admissions are projected to increase 3% annually for 2013-2015, with anticipated growth of the joint replacement program and other programs.

2. Critical Care Unit admissions are projected to increase at 3% annually for 2013-2015.

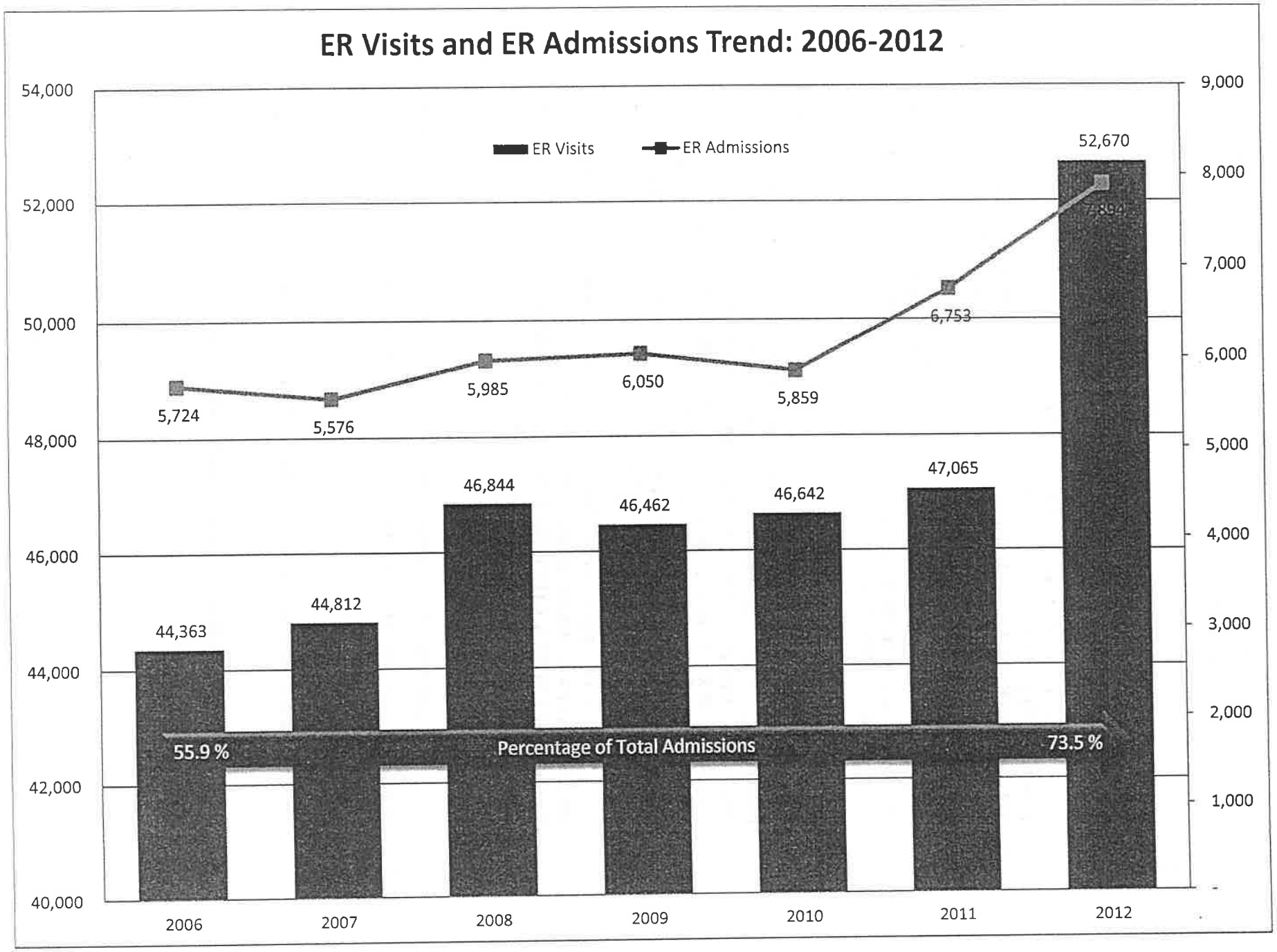
3. NICU admissions are projected to increase 1% annually, 2013-2015.

4. The rehabilitation unit admissions have been discussed in detail in the narrative preceding Exhibit Sixteen.

5. Obstetrics admissions are projected to increase 1% annually in 2013-2015.

6. As a result of the above projections, TriStar Summit Medical Center's overall inpatient utilization is expected to increase from 68.2% to 72.9% by CY2015.

7. In bed units, significant numbers of observation days must be included in any analysis of bed utilization. No longer an occasional use of beds, observation cases now abound as insurors seek to pay lower costs per day for patient care.


ER Visits and ER Admissions Trend: 2006-2012
ER Visits
ER Admissions
54,000
52,000
50,000
48,000
46,000
44,000
42,000
40,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
5,724
5,576
5,985
6,050
5,859
6,753
7,894
44,363
44,812
46,844
46,462
46,642
47,065
52,670
55.9 %
Percentage of Total Admissions
73.5 %
2006
2007
2008
2009
2010
2011
2012

C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.

• ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST $3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.

• THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.

• THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.

• FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1. On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the project architect.

Line A.2, legal, administrative, and consultant fees, include a contingency for expenses of an administrative appeals hearing.

Line A.5, construction cost, was calculated at approximately $149 PSF renovation cost, by HCA Corporate Design and Construction staff. This includes a contingency.

Line A.8 includes both fixed and moveable equipment costs, estimated by HCA Corporate Design and Construction staff.

Line A.9 includes such costs as information systems and telecommunications upgrades and replacements.

PROJECT COSTS CHART -- SUMMIT MEDICAL CENTER REHABILITATION UNIT

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	$ 189,500
2.	Legal, Administrative, Consultant Fees (Excl CON Filing)	50,000
3.	Acquisition of Site	0
4.	Preparation of Site	0
5.	Construction Cost	3,293,660
6.	Contingency Fund	255,342
7.	Fixed Equipment (Not included in Construction Contract)	0
8.	Moveable Equipment (List all equipment over $50,000)	685,000
9.	Other (Specify) IT, telecommunications, misc.	385,000
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	0
2.	Building only	0
3.	Land only	0
4.	Equipment (Specify)	0
5.	Other (Specify)	0
C.	Financing Costs and Fees:	
1.	Interim Financing	63,998
2.	Underwriting Costs	0
3.	Reserve for One Year's Debt Service	0
4.	Other (Specify)	0
D.	Estimated Project Cost (A+B+C)	4,922,500
E.	CON Filing Fee	11,076
F.	Total Estimated Project Cost (D+E)	TOTAL $ 4,933,576

Actual Capital Cost	4,933,576
Section B FMV	0

C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.

a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY SUMMARIZE HOW THE PROJECT WILL BE FINANCED. (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2).

_____A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

_____B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

_____C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;

_____D. Grants--Notification of Intent form for grant application or notice of grant award;

__x___E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or

_____F. Other--Identify and document funding from all sources.

The project will be funded by a cash transfer from the applicant's parent (HCA, Inc.) to the applicant's division office (TriStar Health System). Documentation of financing is provided in Attachment C, Economic Feasibility--2.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

The estimated $3,293,660 renovation construction cost for the project is approximately $149 PSF:

Table Three: Construction Cost PSF		
Construction Cost	**SF of Renovation**	**Construction Cost PSF**
$3,293,660	22,218	$148.24

The 2009-2011 hospital construction projects approved by the HSDA had the following costs per SF. This project's $149 PSF construction cost is very consistent with those ranges, being below the median for hospital renovation projects.

Hospital Construction Cost Per Square Foot
Applications Approved by the HSDA
Years: 2009 – 2011

	Renovated Construction	New Construction	Total Construction
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$273.69/sq ft	$324.00/sq ft	$301.74/sq ft

Source: Health Services and Development Agency, 2012

C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES--DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE FOR THE INSTITUTION. PROJECTED DATA CHART REQUESTS INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., IF THE APPLICATION IS FOR ADDITIONAL BEDS, INCLUDE ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).

See the following pages for these charts, with notes where applicable.

For both the historic and projected charts, there is a "management fee" indicated to an affiliated company (HCA, the parent company). That does not indicate an actual management contract. It is the way HCA allocates its corporate expenses to all the hospitals comprising the company. On the projected data chart that is estimated to be 5.8% of net operating revenues, the amount charged to the hospital last year.

In "Other" expenses, there is an item for an entity named Parallon. It is a wholly owned subsidiary of HCA. It provides support services for the hospitals and allocates the costs of those services back to the hospitals. The services provided by Parallon include:

--All normal Business Office functions (billing, collections, cashiering, etc.)
--Central Scheduling
--Revenue Integrity (chart auditing, charge capture, charge master maintenance)
--Credentialing Functions
--Supply Chain--Materials Management, Accounts Payable & Warehouse
--Payroll functions
--Health Information Management (Medical Records) functions

SUPPLEMENTAL- # 2
April 24, 2013
4:16 pm

HISTORICAL DATA CHART -- SUMMIT MEDICAL CENTER

2013 APR 24 PM 4:17

Give information for the last three (3) years for which complete data are available for the facility or agency.

The fiscal year begins in January.

		Year 2010	Year 2011	Year 2012
A.	Utilization Data (JAR discharge days)	41,759	39,877	42,673
B.	Revenue from Services to Patients			
1.	Inpatient Services	$ 340,144,880	371,674,202	419,876,431
2.	Outpatient Services	240,272,739	236,798,113	277,624,464
3.	Emergency Services	43,587,757	46,936,541	58,231,463
4.	Other Operating Revenue	2,089,089	2,369,663	3,098,447
	(Specify) See notes			
	Gross Operating Revenue	$ 626,094,465	$ 657,778,519	$ 758,830,805
C.	Deductions for Operating Revenue			
1.	Contractual Adjustments	$ 424,831,830	456,728,007	525,148,823
2.	Provision for Charity Care	2,281,357	3,723,069	5,390,825
3.	Provisions for Bad Debt	47,854,780	44,276,197	60,246,469
	Total Deductions	$ 474,967,967	$ 504,727,273	$ 590,786,117
NET OPERATING REVENUE		$ 151,126,498	$ 153,051,246	$ 168,044,688
D.	Operating Expenses			
1.	Salaries and Wages	$ 42,362,204	42,613,777	44,289,349
2.	Physicians Salaries and Wages	0	0	0
3.	Supplies	25,195,000	29,427,000	24,856,680
4.	Taxes	1,257,530	1,202,224	1,339,041
5.	Depreciation	7,020,600	7,017,441	7,489,453
6.	Rent	1,826,000	1,911,000	1,711,583
7.	Interest, other than Capital	251,487	243,557	249,857
8.	Management Fees			
	a. Fees to Affiliates	10,942,208	10,588,601	9,701,320
	b. Fees to Non-Affiliates	0	0	0
9.	Other Expenses (Specify) See notes	51,381,249	47,633,531	60,000,150
	Total Operating Expenses	$ 140,236,278	140,637,131	149,637,433
E.	Other Revenue (Expenses) -- Net (Specify)	$	$	$
NET OPERATING INCOME (LOSS)		$ 10,890,220	$ 12,414,115	$ 18,407,255
F.	Capital Expenditures			
1.	Retirement of Principal	$ 0	$ 0	$ 0
2.	Interest	0	0	0
	Total Capital Expenditures	$ 0	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ 10,890,220	$ 12,414,115	$ 18,407,255

SUPPLEMENTAL- # 2
April 24, 2013
4:16 pm

Notes for Other Operating Revenue

	Year 2010	Year 2011	Year 2012
Fitness Center Dues	7,315	6,175	6,080
Cafeteria Sales	575,217	599,859	611,000
Cafeteria Catering Sales	0	2,855	6,630
Vending Machine Income	19,509	3,474	3,915
Other Income - Recycling	16,497	1,645	1,670
Xray Film Copies	1,220	600	886
Rental/Lease Income	438,401	402,604	398,694
Donations & Gifts - HRSA	50,394	14,862	12,358
Voluntary Paternity Program	7,080	5,540	5,620
NSQIP Grant	0	0	60,000
Child Birth Education	16,865	12,700	12,060
Pharmacy Student Orientation Income	0	17,400	0
Lab Surveillance Honorarium	1,350	900	1,800
Medical Staff Dues	9,400	19,390	19,300
Other Income - Education	803	430	523
Subtotal Other Revenue	1,144,051	1,088,434	1,140,536
Essential Access/DSH Pymt	685,457	755,420	887,998
Amerigroup Settlement	0	0	72,911
Medicare PY Contractual	66,627	248,663	858,838
Champus PY Contractual	54,785	138,977	138,164
TNCare FMAP Pool Distribution	138,169	138,169	0
Subtotal PY Contractuals	945,038	1,281,229	1,957,911
Total Other Operating Revenue	**2,089,089**	**2,369,663**	**3,098,447**

SUPPLEMENTAL- # 2

PROJECTED DATA CHART -- SUMMIT MEDICAL CENTER REHABILITATION UNIT **April 24, 2013 4:16 pm**

Give information for the two (2) years following the completion of this proposal.

The fiscal year begins in January.

2013 APR 24 PM 4 22

			Year 2014	Year 2015
		Admissions	270	284
A.	Utilization Data	Patient Days	3,645	3,834
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 11,880,000	$ 12,996,000
	2. Outpatient Services			
	3. Emergency Services			
	4. Other Operating Revenue (Specify)			
		Gross Operating Revenue	$ 11,880,000	$ 12,996,000
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 6,408,000	$ 7,105,000
	2. Provision for Charity Care	1%	118,800	129,960
	3. Provisions for Bad Debt	4%	475,200	519,840
		Total Deductions	$ 7,002,000	$ 7,754,800
NET OPERATING REVENUE			$ 4,878,000	$ 5,241,200
D.	Operating Expenses			
	1. Salaries and Wages		$ 1,508,000	$ 1,608,000
	2. Physicians Salaries and Wages		0	0
	3. Supplies		281,000	307,000
	4. Taxes		0	0
	5. Depreciation		0	0
	6. Rent		0	0
	7. Interest, other than Capital		0	0
	8. Management Fees			
	a. Fees to Affiliates	(5.8% of NOR)	282,924	303,978
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	See notes	1,227,000	1,306,000
		Total Operating Expenses	$ 3,298,924	$ 3,524,978
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 1,579,076	$ 1,716,222
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 1,579,076	$ 1,716,222

Notes to Projected Data Chart -- SMC Rehabilitation Unit

D.9: Other expenses:

Other expenses:

	Year 2014	Year 2015
Employee Benefits	408,000	440,000
Pro Fees	88,000	92,000
Repairs and Maintenance	107,000	115,000
Rents and Leases	96,000	99,000
Ancillary Clinical Services	94,000	102,000
Insurance	94,000	101,000
Parallon Allocations	340,000	357,000
	1,227,000	1,306,000

Management Fee (5.8 % of NOR - 2012 rate) 282,924 303,978

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Seventeen: Charges, Deductions, Net Charges, Net Operating Income		
	CY2014	**CY2015**
Admissions	270	284
Patient Days	3,645	3,834
Average Gross Charge Per Day	$3,259	$3,390
Average Gross Charge Per Admission	$44,000	$45,761
Average Deduction from Operating Revenue Per Day	$1,921	$2,023
Average Deduction from Operating Revenue Per Admission	$25,933	$27,306
Average Net Charge (Net Operating Revenue) Per Day	$1,338	$1,367
Average Net Charge (Net Operating Revenue) Per Admission	$18,067	$18,455
Average Net Operating Income after Expenses, Per Day	$433	$448
Average Net Operating Income after Expenses, Per Admission	$5,848	$6,043

Source: Projected Data Chart for Rehabilitation, Hospital management.

C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.

The project's most frequent charges are shown in response to C(II).6.B below. The introduction of the new rehabilitation service will not affect any other hospital charges, because it will operate with a positive revenue margin, making it unnecessary to shift costs to other hospital services.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

The projected average gross charge for the new rehabilitation unit in CY2014 will be consistent with the average gross charges for similar area projects approved by the Agency or in operation already, once reasonable adjustments are made for annual inflation CY2014. No charge information is publicly available for rehabilitation units in hospitals because the Joint Annual Reports do not contain revenue data specific to inpatient rehabilitation services. It is available for a rehabilitation hospital, however, as shown below. Following is available charge data. (Cases are discharges or admissions.)

Table Eighteen: Year One Charges of Similar Facilities Compared to CY2014 Charge of This Project

Provider	Gross / **Net** Charges	Cases	Days	Gross/**Net** Charges Per Case (NOR)	Gross/**Net** Charges Per Day
HealthSouth Rehab'n Hospital Williamson County (CN1002-059)	$18,447,324/ **$8,231,016**	537	7,245	$34,353 / **$15,327**	$2,546 / **$1,136**
VU Stallworth Rehabilitation Hospital (2011 JAR)	$56,921,124 / **$25,001,544**	1,713	22,671	$33,228 / **$14,595**	$2,511 / **$1,103**
Southern Hills Medical Center (CN 1111-048)	$19,085,892 / $5,522,620	347	4,530	$55,003 / **$15,915**	$4,213 / **$1,220**
THIS PROJECT (2014)	$11,880,000 / **$4,878,000**	270	3,645	$44,000 / **$18,067**	$3,259 / **$1,338**

Source: HSDA Records; Joint Annual Reports; Projected Data Chart

There is no publicly available data by which surgical bed charges can be compared to those of other hospitals in the service area.

Table Nineteen on the following page shows the most frequent procedures to be performed, with their current Medicare reimbursement, and their projected Years One and Two utilization and average gross charges.

Table Nineteen: Summit Medical Center
Charge Data for Most Frequent Admissions Diagnoses

SERVICE: REHABILITATION UNIT

Admission Code	Descriptor	Current Medicare Allowable	Average Gross Charge			Utilization (Admissions)		
			Current	Year 1	Year 2	Current	Year 1	Year 2
1	Stroke	49,091	N/A	50,254	52,264	N/A	70	74
2	Traumatic Brain Injury	37,646	N/A	38,538	40,080	N/A	15	16
6	Neurological	37,345	N/A	38,230	39,759	N/A	44	46
7	Fracture of Lower Extremity	39,152	N/A	40,080	41,683	N/A	26	27
10	Amputation, Lower Extremity	42,766	N/A	43,779	45,530	N/A	7	7
17	Mult Trauma w/o Brain or Sp Cord Inj	40,658	N/A	41,621	43,286	N/A	5	6
	Subtotal, Most Frequent			43,920	45,691		167	176
	All Other			44,130	45,872		103	108
	Total			44,000	45,760		270	284

SERVICE: ORTHOPEDIC UNIT

	Descriptor	Current Medicare Allowable	Average Gross Charge			Utilization (Admissions)		
			Current	Year 1	Year 2	Current	Year 1	Year 2
470	Major Joint Replacement W/O MCC	11,741	62,786	65,297	67,909	226	233	240
469	Major Joint Replacement W/ MCC	19,162	94,466	98,245	102,174	17	18	19
481	Hip Fracture	10,840	46,589	48,453	50,391	78	80	82
483	Major Reatt, Upper Extrem W/MCC	14,184	61,385	63,840	66,394	17	18	19
484	Major Reatt, Upper Extrem W/O MCC	11,739	57,444	59,742	62,131	6	6	6
	Subtotal, Most Frequent	N/A	0	0	0	344	355	366
	All Other	N/A	75,643	78,669	81,815	209	215	221
	Total		-	-	-	553	570	587

Source: Hospital Management

C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.

The Projected Data Chart and charge information in the application demonstrate that the rehabilitation unit will be cost-effective, operating with a positive financial margin, while maintaining a competitive charge structure for payors.

C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.

Summit generates a large number of referrals to acute rehabilitation programs each year. An even larger number of discharges have been identified, who are eligible for such transfers. The proposed unit will be sufficiently utilized in its first two years to operate with a positive financial margin, at charges that are comparable to those of other such programs in the area.

The same is true of the orthopedic unit. Summit's surgical program is highly utilized and the growth in its joint replacement program will ensure strong utilization of the proposed orthopedic beds.

C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.

Like Summit Medical Center, this proposed unit will serve the groups listed above. Indigent care is projected at approximately 1% of gross revenues annually and Medicare and TennCare/Medicaid are projected at a combined 55% of services.

Table Twenty: Medicare and TennCare/Medicaid Gross Revenues, Year One		
	Medicare	**TennCare/Medicaid**
Gross Revenue	$6,177,600	$356,400
Percent of Gross Revenue	52%	3%

Source: Hospital management

C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.

These are provided as Attachment C, Economic Feasibility--10.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:
A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.
B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

With respect to construction, the project requires no new construction. It will be done entirely by renovation.

With respect to alternatives, there is no alternative way to make acute inpatient rehabilitation more accessible to residents of the eastern suburban edge of Davidson County and adjoining western Wilson County. Acute rehabilitation is a hospital-based program and Summit is the only hospital between the rehabilitation units at Baptist Hospital in central Davidson County, and UMC McFarland Hospital in central Wilson County--a distance of approximately 32 miles. Deployment of rehabilitation at Summit will be consistent with HSDA decisions for other suburban areas around Nashville.

While rehabilitation is available in nursing home programs in the service area, a hospital-based acute rehabilitation program allows patients to receive more intensive therapies (3 or more hours per day), and is appropriate for patients who need that. The project also permits Summit to offer and control a complete continuum of care for its patients whose discharge from the initial stay needs to proceed seamlessly into acute rehabilitation, with their medical team conveniently close.

Conversion of medical-surgical beds to rehabilitation beds or specialty orthopedic beds is not feasible. The annual average occupancy of the hospital's 110 medical-surgical beds reached 83.3% CY2012 and further increases are anticipated. As discussed in prior sections of the application, the weekday occupancies were even higher.

SUPPLEMENTAL

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

Following are the facilities most frequently utilizes in its discharge planning:

Skilled Nursing- McKendree, Mt. Juliet Healthcare, Donelson Place, Lebanon Health and Rehabilitation

Hospice- Alive Hospice, Odyssey, Avalon, Asera Care

Home Health- Suncrest, Gentevia, and Amedysis Home Health Care of Middle

Home Infusion- Walgreens, IV Solutions, Coram

DME- Medical Necessities, At Home Medical, Apria, All-Star

Summit Medical Center is fully contracted with all available TennCare MCO's in the Middle Tennessee Region. They are as follows:

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
AmeriGroup	contracted
United Community Healthcare Plan (formerly AmeriChoice)	contracted
Select	contracted

C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.

The project will provide easier access to acute inpatient rehabilitation, for residents of eastern Davidson County and western Wilson County who are being discharged from initial acute care stays in Davidson County hospitals--especially Summit Medical Center--and who would prefer the Hermitage location to a downtown or Wilson County location.

The project consolidates HCA TriStar's psychiatric care resources in Nashville, at its two central Davidson County campuses (Skyline Madison and Centennial Pavilion), freeing up beds in its Davidson County suburban hospitals for broader-based acute services for which there is a greater local need.

The project adds only a net of 2 rehabilitation beds to the service area but at the same time it decreases total licensed acute care bed complements in the area by 10 beds.

The impact on non-HCA rehabilitation providers will be minimal. In CY2012, the majority of Summit's discharges to acute rehabilitation programs in Nashville were to sister HCA hospitals.

The project's impact on TriStar Skyline Medical Center's adult psychiatric program will be to increase the efficiency and occupancy of the Skyline program:

1. Skyline's Adult Psychiatric Units = 100 beds = 36,500 patient days of capacity
2. In CY2012, Skyline provided 24,163 days of care in those units = 66.2% occupancy
3. In CY2012, Summit provided 4,294 days of care in its unit = 58.8% occupancy
4. The combined Skyline and Summit CY2012 days = 28,457 days of care.
5. Had those combined days been provided in Skyline's 100 adult psychiatric beds, their occupancy would have been 28,457/36,500 = 78%.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

Please see the following page for Table Twenty-Two, showing projected FTE's and salary ranges for both units.

The Department of Labor and Workforce Development website indicates the following Nashville area's hourly salary information for the clinical positions in this project:

Table Twenty-One: TDOL Surveyed Average Salaries for the Region				
Position	**Entry Level**	**Median**	**Mean**	**Experienced**
RN	$21.55	$28.90	$31.00	$35.70
Physical Therapist	$26.25	$36.40	$35.10	$39.55
Physical Therapy Assistant	$16.70	$23.60	$23.30	$26.60
Occupational Therapist	$29.80	$34.10	$34.40	$36.70
Certified OT Assistant	$19.75	$22.85	$24.35	$26.70
Social Worker	$16.50	$29.45	$26.80	$31.95

Table Twenty-Two: Summit Medical Center Acute Rehabilitation and Orthopaedic Units Staffing Requirements (Revised on Supplemental Cycle)				
Position Type (RN, etc.)	**Current FTE's**	**Year One FTE's**	**Year Two FTE's**	**Salary Range (Hourly)**
REHABILITATION UNIT				
RN	N/A	5.40	7.00	22.00 - 32.49
LPN	N/A	1.35	1.70	15.40 - 17.00
Program Director	N/A	1.00	1.00	35.00 - 50.00
Nurse Manager	N/A	1.00	1.00	25.00 - 40.00
Unit Secretary	N/A	1.00	1.00	15.36 - 16.96
Admission Coordinator	N/A	1.00	1.00	14.42 - 15.92
Physical Therapists	N/A	2.00	2.00	27.46 - 44.40
Physical Therapy Assistant	N/A	1.00	1.00	22.69 - 32.91
Occupational Therapy	N/A	2.00	2.00	27.46 - 39.82
COTA	N/A	1.00	1.00	22.69 - 32.91
Speech Therapy	N/A	2.00	2.00	27.46 - 44.40
Case Manager/Social Worker	N/A	1.00	1.50	20.63 - 36.20
Outreach Liaisons/PPS Coordinator	N/A	3.80	3.80	19.00 - 23.00
Total FTE's, Rehabilitation Unit		23.55	26.00	
ORTHOPAEDIC UNIT				
RN	N/A	8.40	8.52	22.00 - 32.49
Certified Nurse Technician	N/A	0.00	0.00	15.40 - 17.00
Nurse Director	N/A	0.50	0.50	35.00 - 50.00
Unit Secretary	N/A	0.50	0.50	15.36 - 16.96
Total FTE's, Orthopaedic Unit		9.40	9.52	
Total FTE's, Third Floor Project		32.95	35.52	

Source: Hospital Management

C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.

HCA hospitals nationwide and in Middle Tennessee have established numerous acute inpatient rehabilitation programs and TriStar anticipates no difficulties in attracting the nursing, therapy, support staff, and Medical Director required for an effective program at Summit Medical Center.

C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.

The applicant so verifies.

C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).

StoneCrest is a clinical rotation site for numerous students in the health professions. The schools with which Summit has student affiliation agreements are:

Absolute Medical
Austin Peay University
Belmont University
Cardiac and Vascular Institute
Cedar Crest College
Columbia State Community College
Cumberland University
ITT Technical
Middle TN School of Anesthesia
Middle Tennessee State University
Southeastern University
South University
Tennessee State University
Tennessee Tech
University of Houston
Trevecca Nazarene
University of Phoenix
University of Tennessee
Vanderbilt University
Weber State University
West Virginia Wesleyan College
Western KY University
Volunteer State Community College

In CY2011, Summit Medical Center served as a training rotation site for 415 students from these schools, in the following disciplines and programs: Nursing (174); EMT/Paramedic (68); Anesthesia Tech (72); Pharmacy Tech (35); Nutrition (3); Respiratory Therapy (25); Medical Imaging (31); Physician's Assistant (2); and Physical Therapy (5).

C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.

The applicant so verifies.

C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION

LICENSURE: Board for Licensing of Health Care Facilities
Tennessee Department of Health

CERTIFICATION: Medicare Certification from CMS
TennCare Certification from TDH

ACCREDITATION: Joint Commission
1. Hospital (current)
2. Certified Primary Stroke Center (proposed)

C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by the Joint Commission.

C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C). Summit Medical Center is also a Joint Commission-certified Primary Stroke Center, one of only 18 in Tennessee.

C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.

None.

C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.

None.

C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

PROOF OF PUBLICATION

Attached.

DEVELOPMENT SCHEDULE

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

Not applicable. The applicant anticipates completing the project within the period of validity.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

July 24, 2013

Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed	1	7/13
2. Construction documents approved by TDH	60	9/13
3. Construction contract signed	60	9/13
4. Building permit secured	70	9/13
5. Site preparation completed	na	na
6. Building construction commenced	71	10/13
7. Construction 40% complete	100	11/13
8. Construction 80% complete	120	12/13
9. Construction 100% complete	140	12/13
10. * Issuance of license	155	12/13
11. *Initiation of service	160	1/14
12. Final architectural certification of payment	250	3/14
13. Final Project Report Form (HF0055)	280	4/14

*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

SUMMIT MEDICAL CENTER REHABILITATION UNIT

AFFIDAVIT 2013 APR 15 PM 3 18

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he/she is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

John L Wellborn
SIGNATURE/TITLE

Sworn to and subscribed before me this 10 day of APRIL (Month), 2013 (Year) a Notary Public in and for the County/State of DAVIDSON CO., TN.

NOTARY PUBLIC

TIFFANY B. POULOSE
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY

My commission expires ~~04/10/13~~ TBC (Month/Day)
1-11

INDEX OF ATTACHMENTS

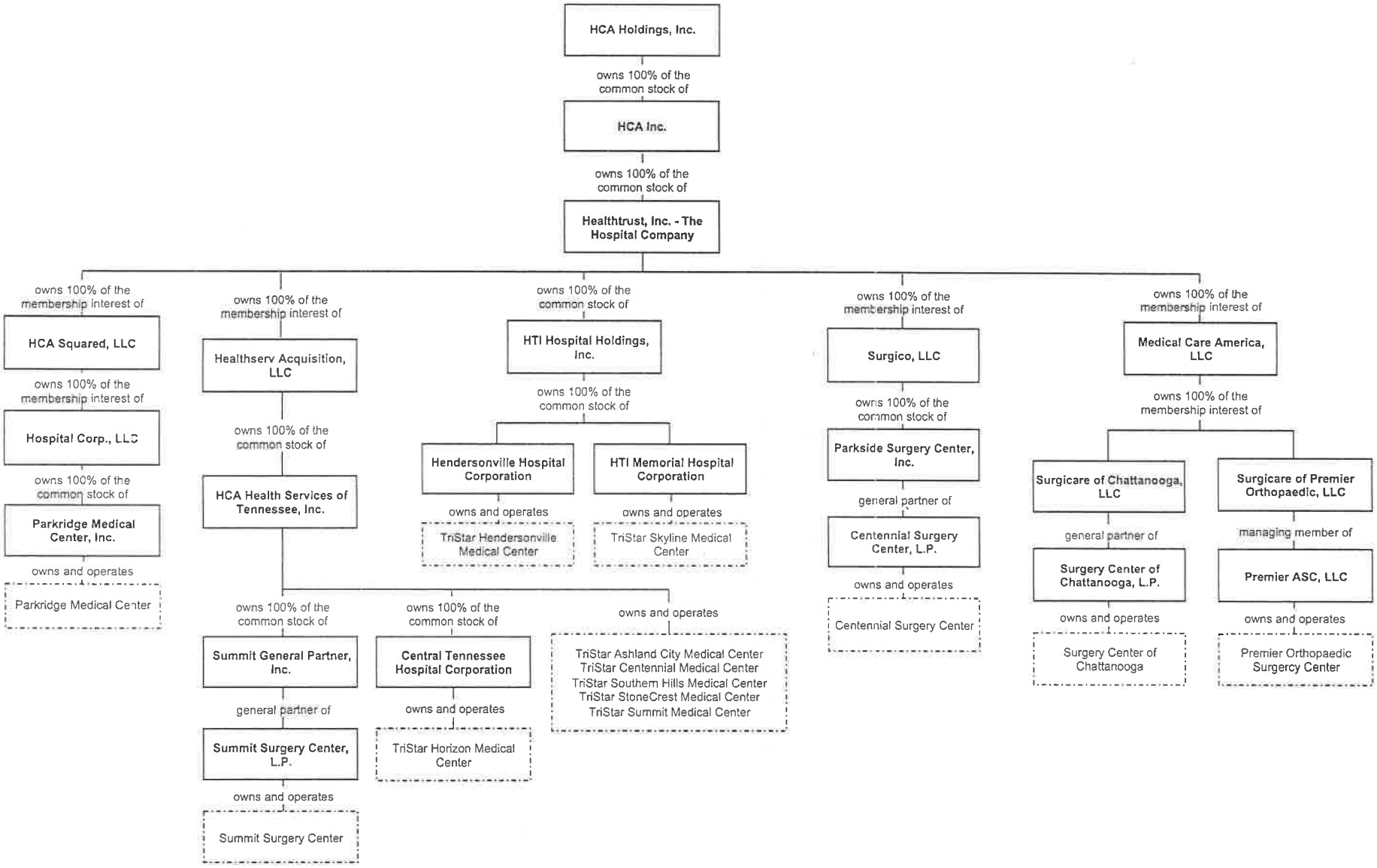
A.4	Ownership--Legal Entity and Organization Chart (if applicable)
A.6	Site Control
B.II.A.	Square Footage and Costs Per Square Footage Chart
B.III.	Plot Plan
B.IV.	Floor Plan

C, Need--3	Service Area Maps
C, Economic Feasibility--1	Documentation of Construction Cost Estimate
C, Economic Feasibility--2	Documentation of Availability of Funding
C, Economic Feasibility--10	Financial Statements
C, Orderly Development--7(C)	TDH Inspection & Plan of Correction

Miscellaneous Information

Support Letters

A.4--Ownership
Legal Entity and Organization Chart


HCA Holdings, Inc.
owns 100% of the common stock of
HCA Inc.
owns 100% of the common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of the membership interest of
HCA Squared, LLC
owns 100% of the membership interest of
Hospital Corp., LLC
owns 100% of the common stock of
Parkridge Medical Center, Inc.
owns and operates
Parkridge Medical Center
owns 100% of the membership interest of
Healthserv Acquisition, LLC
owns 100% of the common stock of
HCA Health Services of Tennessee, Inc.
owns 100% of the common stock of
Summit General Partner, Inc.
general partner of
Summit Surgery Center, L.P.
owns and operates
Summit Surgery Center
owns 100% of the common stock of
HTI Hospital Holdings, Inc.
owns 100% of the common stock of
Hendersonville Hospital Corporation
owns and operates
TriStar Hendersonville Medical Center
HTI Memorial Hospital Corporation
owns and operates
TriStar Skyline Medical Center
owns 100% of the common stock of
Central Tennessee Hospital Corporation
owns and operates
TriStar Horizon Medical Center
owns and operates
TriStar Ashland City Medical Center
TriStar Centennial Medical Center
TriStar Southern Hills Medical Center
TriStar StoneCrest Medical Center
TriStar Summit Medical Center
owns 100% of the membership interest of
Surgico, LLC
owns 100% of the common stock of
Parkside Surgery Center, Inc.
general partner of
Centennial Surgery Center, L.P.
owns and operates
Centennial Surgery Center
owns 100% of the membership interest of
Medical Care America, LLC
owns 100% of the membership interest of
Surgicare of Chattanooga, LLC
general partner of
Surgery Center of Chattanooga, L.P.
owns and operates
Surgery Center of Chattanooga
Surgicare of Premier Orthopaedic, LLC
managing member of
Premier ASC, LLC
owns and operates
Premier Orthopaedic Surgercy Center

TENNESSEE FACILITIES OWNED BY HCA, INC.

Centennial Medical Center	2300 Patterson Str		Nashville	TN	37203
Parthenon Pavilion	2401 Parman Place		Nashville	TN	37203
Sarah Cannon Cancer Center	250 25th Avenue North	Suite 110	Nashville	TN	37203
Sarah Cannon Research Institute	3322 West End Avenue	Suite 900	Nashville	TN	37203
Women's Hospital	2221 Murphy Avenue		Nashville	TN	37203
Centennial Surgery Center	345 23rd Ave N	Suite 201	Nashville	TN	37203-1524
Greenview Regional Hospital	1801 Ashley Circle		Bowling Green	KY	42104-9024
Hendersonville Medical Center	355 New Shackle Island Road		Hendersonville	TN	37075
Horizon Medical Center	111 Highway 70 East		Dickson	TN	37055
Natchez Imaging	101 Natchez Park Drive		Dickson	TN	37055
Radiation Oncology @ SCCC	105 Natchez Park Drive		Dickson	TN	37055
TN Oncology @ SCCC	103 Natchez Park Drive,		Dickson	TN	37055
Parkridge East Hospital	941 Spring Creek Road		Chattanooga	TN	37412
Parkridge Medical Center	2333 McCallie Avenue		Chattanooga	TN	37404
Parkridge Valley Hospital	2200 Morris Hill Road		Chattanooga	TN	37421
Portland Medical Center	105 Redbud Drive		Portland	TN	37148
Skyline Medical Center	3441 Dickerson Pike		Nashville	TN	37207
Skyline Madison Campus	500 Hospital Drive		Madison	TN	37115
Southern Hills Medical Center	391 Wallace Road		Nashville	TN	37211
Southern Hills Surgical Center	360 Wallace Road		Nashville	TN	37212
StoneCrest Medical Center	200 StoneCrest Boulevard		Smyrna	TN	37167
Summit Medical Center	5655 Frist Boulevard		Hermitage	TN	37076
Summit Surgery Center	3901 Central Pike	Suite 152	Hermitage	TN	37076

FEB. 27, 2012

B.II.A.--Square Footage and Costs Per Square Footage Chart

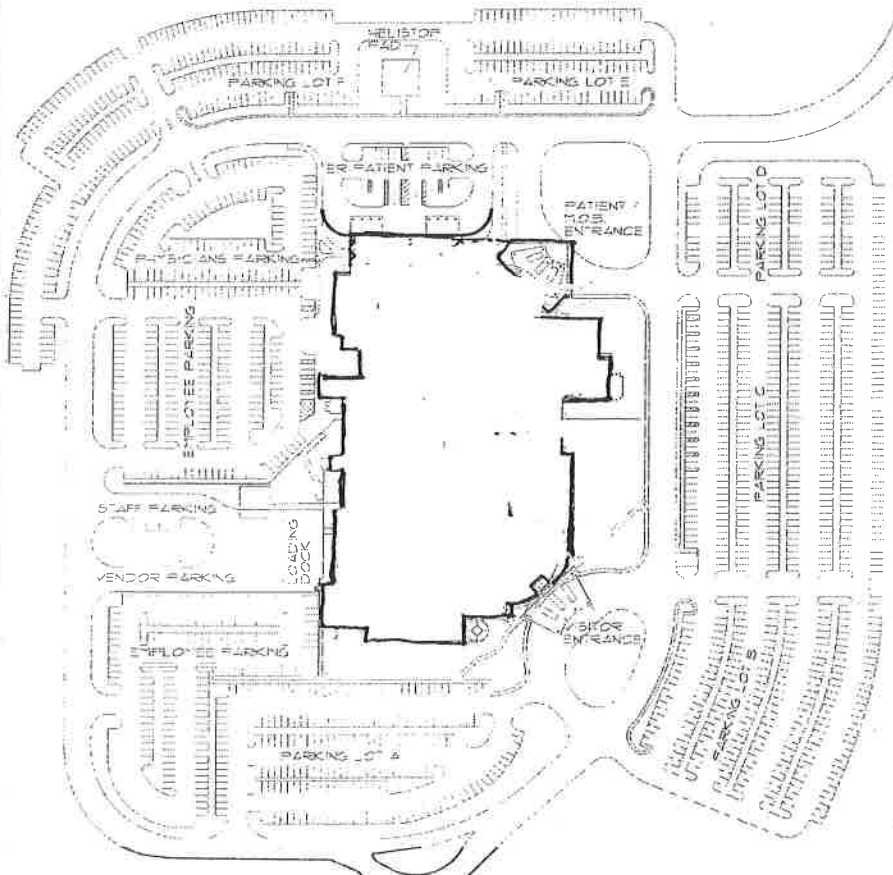
SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
Inpatient Rehab	N/A	N/A	N/A	3RD FL	12,192	N/A	12,192	1,807,342	N/A	1,807,342
Ortho/Med.Surgical	N/A	N/A	N/A	3RD FL	7,037	N/A	7,037	1,043,165	N/A	1,043,165
B. Unit/Depart. GSF Sub-Total					19,229			2,850,507		2,850,507
C. Mechanical/ Electrical GSF					N/A					
D. Circulation /Structure GSF					2,989			443,153		443,153
E. Total GSF					22,218			3,293,660		3,293,660

99

SUMMIT MEDICAL CENTER
3RD FLOOR REHABILITATION AND
TOTAL JOINT UNIT RENOVATION
GS&P Project No. 29103.00
April 8, 2013

B.III.--Plot Plan



OLD HICKORY BLVD.

47.85± ACRES

CENTRAL PIKE

CENTRAL PIKE

G S & P

SITE PLAN

8' 0 8' 16' 24'

REVISION

PRELIMINARY NOT FOR CONSTRUCTION

SUMMIT MEDICAL CENTER

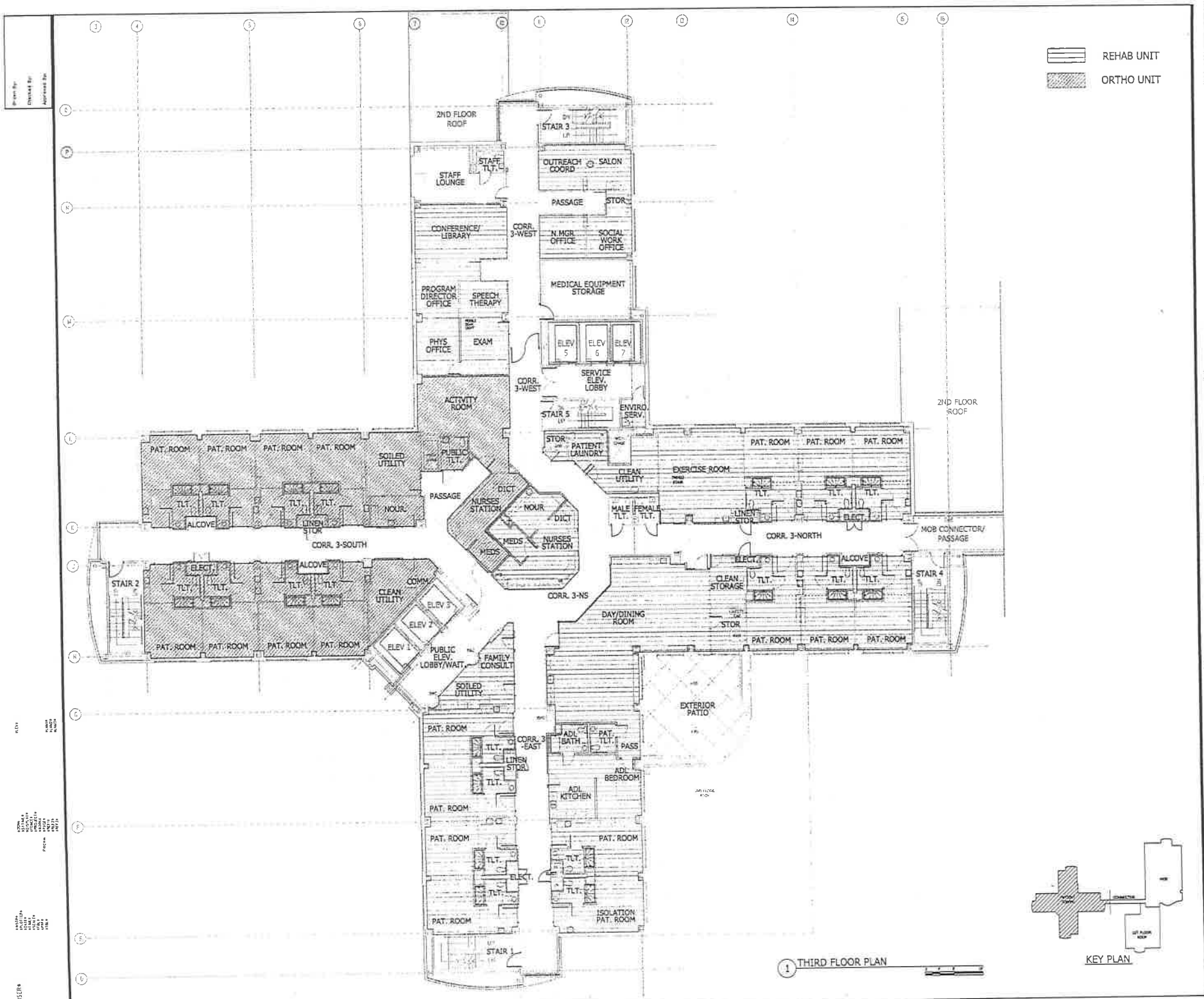
GRESHAM SMITH AND PARTNERS

Nashville, Tennessee ■ Memphis, Tennessee ■ Jacksonville, Florida ■ Knoxville, Tennessee ■ Fort Lauderdale, Florida ■ Columbus, Ohio ■ Cincinnati, Ohio ■ Charlotte, North Carolina ■ Birmingham, Alabama ■ Evansville, Indiana

Design Services For The Built Environment

G S & P

B.IV.--Floor Plan



G S & P

Design Services For The Built Environment

Atlanta
Birmingham
Cincinnati
Columbus
Dallas
Fort Lauderdale
Jackson
Jacksonville
Knoxville
Louisville
Memphis
Nashville
Richmond
Tampa

GRESHAM SMITH AND PARTNERS

CONTRACT DOCUMENTS

101

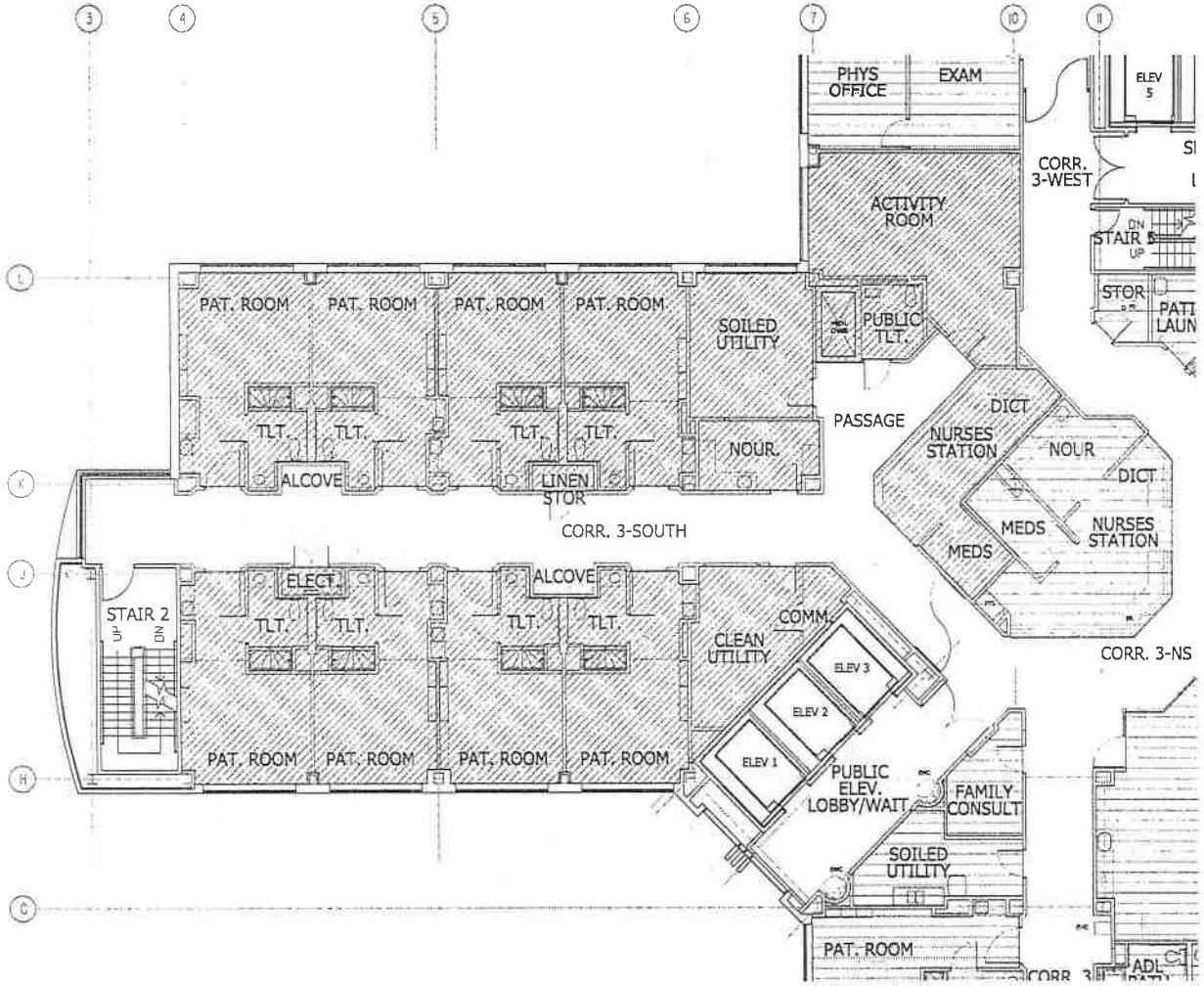
Summit Medical Center

Hermitage, TN

Third Floor Rehabilitation & Total Joint Unit Renovations

REVISION

No.	Date	Revision



1 THIRD FLOOR PLAN - ENLARGED ORTHO UNIT

GS&P

Design Services For The Built Environment

Atlanta
Birmingham
Cincinnati
Columbus
Dallas
Fort Lauderdale
Jackson
Jacksonville
Knoxville
Louisville
Memphis
Nashville
Richmond
Tampa

GRESHAM SMITH AND PARTNERS

CONTRACT DOCUMENTS

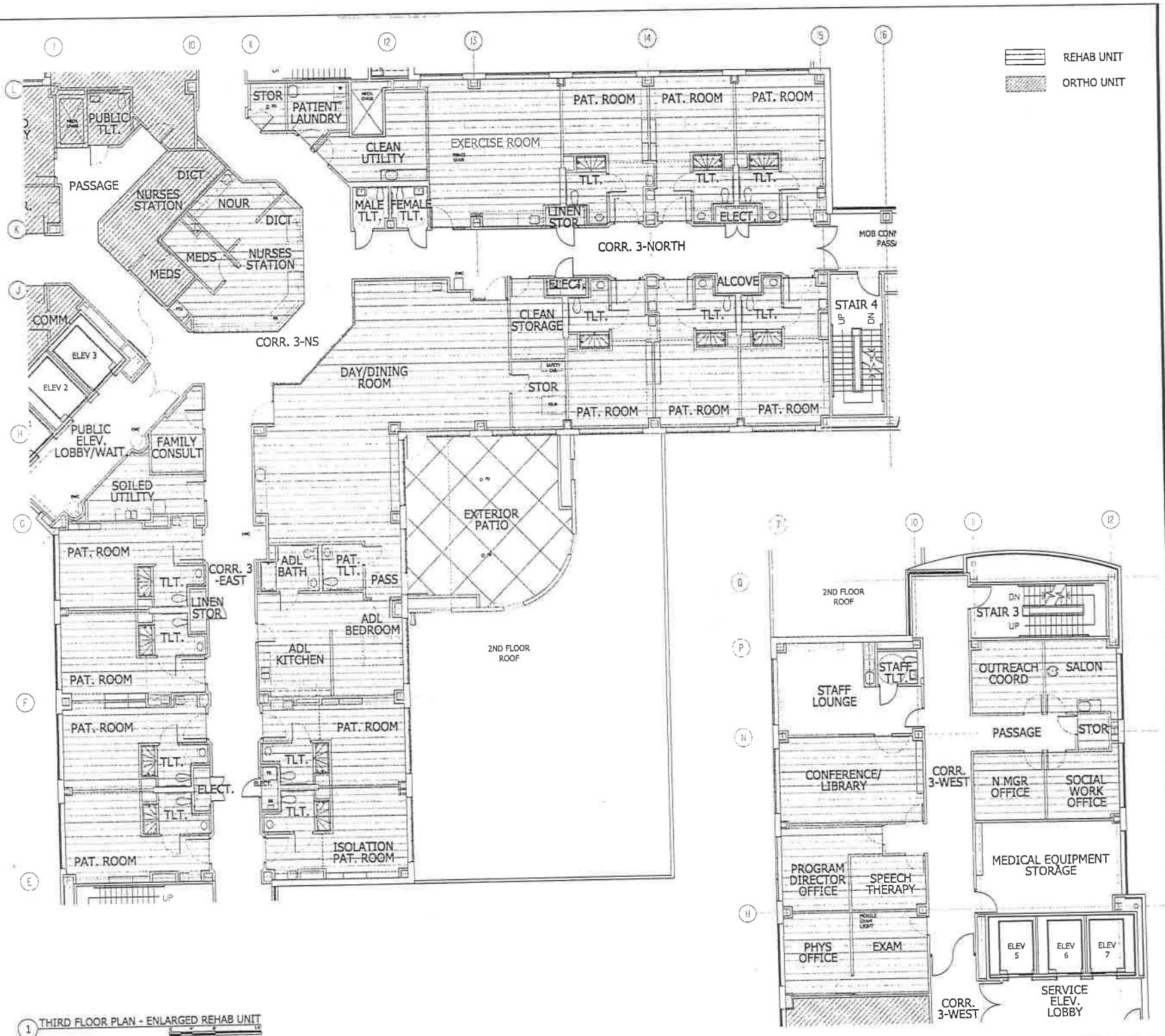
104

Summit Medical Center

Hermitage, TN

Third Floor Rehabilitation & Total Joint Unit Renovations

REVISION		
No.	Date	Revision



1 THIRD FLOOR PLAN - ENLARGED REHAB UNIT

G S & P

Design Services For The Built Environment

Atlanta
Birmingham
Cincinnati
Columbus
Dallas
Fort Lauderdale
Jackson
Jacksonville
Knoxville
Louisville
Memphis
Nashville
Richmond
Tampa

GRESHAM SMITH AND PARTNERS

CONTRACT DOCUMENTS

Summit Medical Center

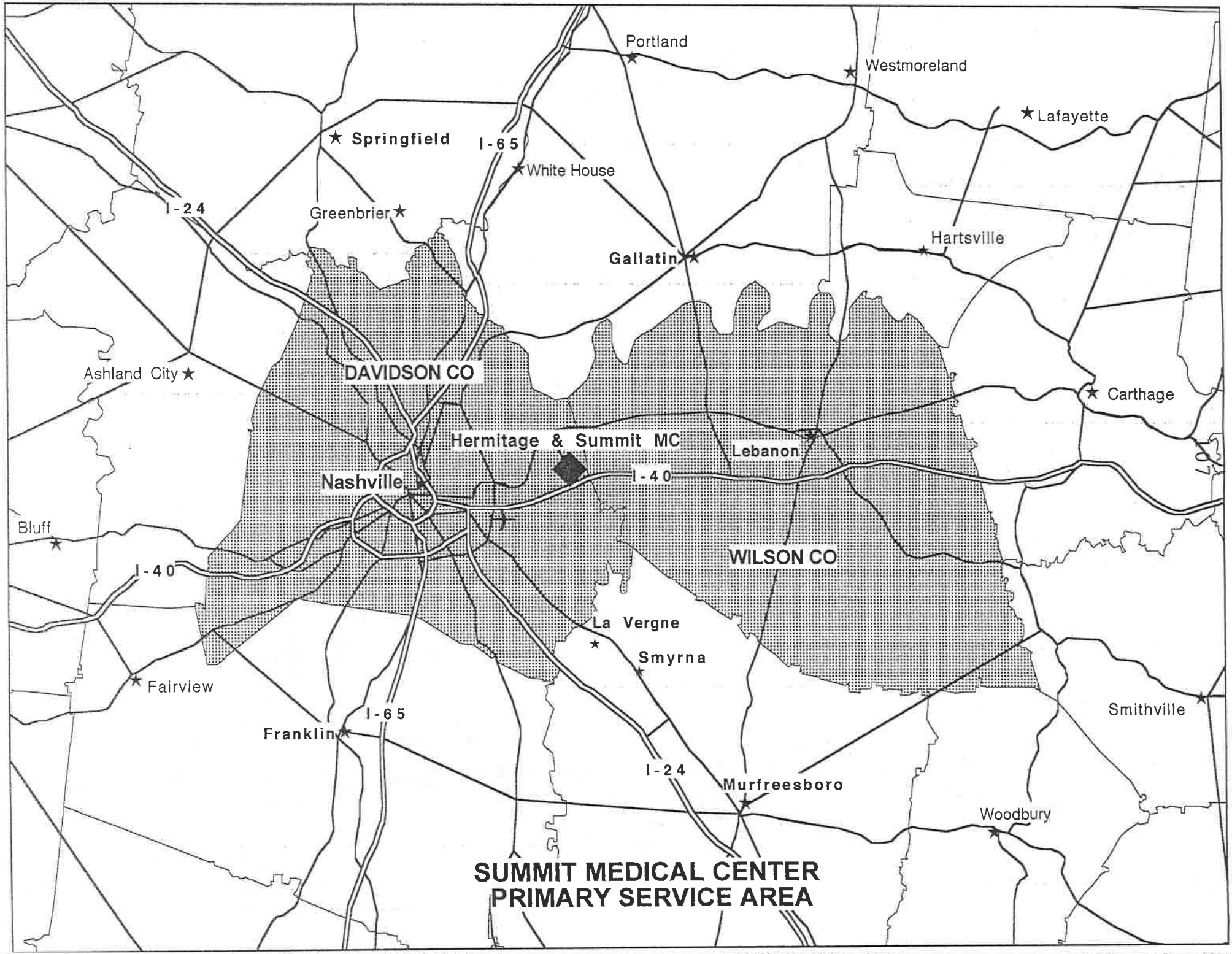
Hermitage, TN

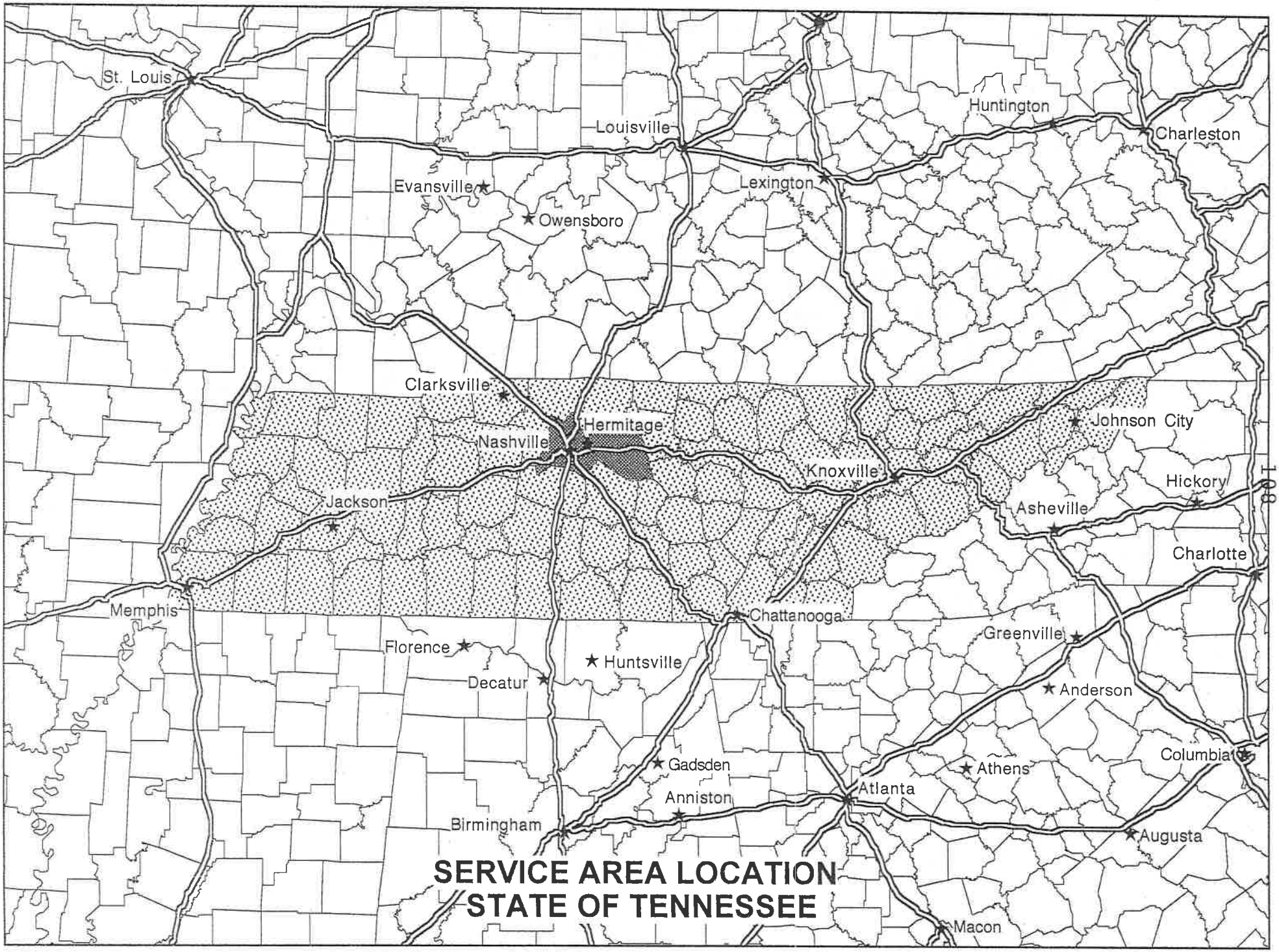
Third Floor Rehabilitation & Total Joint Unit Renovations

REVISION

No.	Date	Revision

C, Need--3
Service Area Maps


Portland
Westmoreland
Lafayette
Springfield
I-65
White House
I-24
Greenbrier
Hartsville
Gallatin
Ashland City
DAVIDSON CO
Carthage
Hermitage & Summit MC
Lebanon
Nashville
I-40
Bluff
WILSON CO
I-40
La Vergne
Smyrna
Fairview
I-65
Smithville
Franklin
I-24
Murfreesboro
Woodbury
SUMMIT MEDICAL CENTER
PRIMARY SERVICE AREA


St. Louis
Louisville
Huntington
Charleston
Evansville
Lexington
Owensboro
Clarksville
Hermitage
Nashville
Johnson City
Knoxville
Hickory
Jackson
Asheville
Charlotte
Memphis
Chattanooga
Greenville
Florence
Huntsville
Decatur
Anderson
Columbia
Gadsden
Athens
Atlanta
Anniston
Birmingham
Augusta
Macon
SERVICE AREA LOCATION
STATE OF TENNESSEE

C, Economic Feasibility--1
Documentation of Construction Cost Estimate

GRESHAM
SMITH AND
PARTNERS

April 8, 2013

Mr. Jeff Whitehorn, CHE
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Subject: **Verification of Construction Cost Estimates**
3rd Floor InPatient Rehabilitation Unit
Summit Medical Center
Hermitage, Tennessee
GS&P Project No. 29103.00 / 00.3

Gresham Smith and Partners, Inc., an architectural/engineering firm in Nashville, Tennessee, has reviewed the cost data provided by HCA for the above referenced project, for which this firm has provided a preliminary design. The stated renovated construction cost for this 22,218 SF area is $3,293,660. [In providing opinions of probable construction cost, the Client understands that the Consultant has no control over the cost or availability of labor, equipment or materials, or over market conditions or the Contractor's method of pricing, and that the Consultant's opinions of probable construction costs are made on the basis of the Consultant's professional judgment and experience. The Consultant makes no warranty, express or implied, that the bids or the negotiated cost of the Work will not vary from the Consultant's opinion of probable construction cost.]

It is our opinion that at this time, the projected renovated construction cost is reasonable for this type and size of project and compares appropriately with similar projects in this market.

The building codes applicable to this project will be:

International Building Code, 2006
NFPA 101 Life Safety Code, 2006
FGI Guidelines for Design & Construction of Healthcare Facilities, 2010
ANSIA-117.1, 2003

Sincerely,

Kenneth A. Priest, AIA, NCARB, LEED AP
License No. 16010

bma

C, Economic Feasibility--2
Documentation of Availability of Funding

TriStar Health

TriStarHealth.com

110 Winners Circle, First Floor
Brentwood, TN 37027
(615) 886-4900

April 10, 2013

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, TN 37243

Re: CON Application for 12 bed Acute Rehabilitation Unit and 8 bed Med/Surg Unit

Dear Ms. Hill,

TriStar Summit Medical Center is applying for a Certificate of Need to add the subject service beginning next January.

As Chief Financial Officer of TriStar Health System, the HCA Division Office to which this facility will belong, I am writing to confirm that HCA Holdings, Inc. will provide through TriStar the approximately $4,934,000 in capital costs required to implement this project. HCA Holdings, Inc.'s financial statements are provided in the application.

Sincerely,

C. Eric Lawson
Chief Financial Officer
TriStar Division of HCA

C, Economic Feasibility--10
Financial Statements

Financial Statements - Balance Sheet

Month				Year to Date		
Begin	Change	Ending		Begin	Change	Ending
			CURRENT ASSETS			
10,361	22,637	32,998	Cash & Cash Equivalents	-89,980	122,978	32,998
			Marketable Securities			
			PATIENT ACCOUNTS RECEIVABLES			
46,294,146	1,492,717	47,786,863	Patient Receivables	41,961,579	5,825,284	47,786,863
			Less Allow for Govt Receivables			
-25,242,146	-617,825	-25,859,971	Less Allow - Bad Debt	-20,930,460	-4,929,511	-25,859,971
21,052,000	874,892	21,926,892	Net Patient Receivables	21,031,119	895,773	21,926,892
			FINAL SETTLEMENTS			
-260,961	0	-260,961	Due to/from Govt Programs	217,738	-478,699	-260,961
			Allowances Due Govt Programs			
-260,961	0	-260,961	Net Final Settlements	217,738	-478,699	-260,961
20,791,039	874,892	21,665,931	Net Accounts Receivables	21,248,857	417,074	21,665,931
5,020,388	-36,555	4,983,833	Inventories	4,987,414	-3,581	4,983,833
828,717	1,879,312	2,708,029	Prepaid Expenses	981,317	1,726,712	2,708,029
95,170	-6,199	88,971	Other Receivables	37,582	51,389	88,971
26,745,675	2,734,087	29,479,762	Total Current Assets	27,165,190	2,314,572	29,479,762
			PROPERTY, PLANT & EQUIPMENT			
6,124,510	0	6,124,510	Land	6,124,510	0	6,124,510
48,526,104	-45,000	48,481,104	Bldgs & Improvements	48,018,314	462,790	48,481,104
84,781,003	238,887	85,019,890	Equipment - Owned	84,501,202	518,688	85,019,890
1,411,670	752,802	2,164,472	Equipment - Capital Leases	1,411,670	752,802	2,164,472
379,542	-258,282	121,260	Construction in Progress		121,260	121,260
141,222,829	688,407	141,911,236	Gross PP&E	140,055,696	1,855,540	141,911,236
-93,801,376	-550,859	-94,352,235	Less Accumulated Depreciation	-88,993,708	-5,358,527	-94,352,235
47,421,453	137,548	47,559,001	Net PP&E	51,061,988	-3,502,987	47,559,001
			OTHER ASSETS			
			Investments			
0	0	0	Notes Receivable	0	0	0
10,027,657	0	10,027,657	Intangible Assets - Net	10,027,657	0	10,027,657
			Investments in Subsidiaries			
			Other Assets			
10,027,657	0	10,027,657	Total Other Assets	10,027,657	0	10,027,657
84,194,785	2,871,635	87,066,420	Grand Total Assets	88,254,835	-1,188,415	87,066,420
			CURRENT LIABILITIES			
3,567,531	1,854,638	5,422,169	Accounts Payable	3,451,954	1,970,199	5,422,153
4,238,328	363,342	4,601,670	Accrued Salaries	3,821,214	780,456	4,601,670
1,521,449	11,931	1,533,380	Accrued Expenses	1,385,335	148,045	1,533,380
16,453	-182	16,271	Accrued Interest	18,332	-2,061	16,271
			Distributions Payable			
913,729	132,726	1,046,455	Curr Port - Long Term Debt	864,510	181,945	1,046,455
12,808	1,582	14,390	Other Current Liabilities	12,229	2,161	14,390
			Income Taxes Payable			
10,270,298	2,364,037	12,634,335	Total Current Liabilities	9,553,574	3,080,745	12,634,319
			LONG TERM DEBT			
2,586,519	544,524	3,131,043	Capitalized Leases	3,426,203	-295,160	3,131,043
-235,513,132	-8,606,477	-244,119,609	Inter/Intra Company Debt	-209,585,656	-34,533,953	-244,119,609
			Other Long Term Debts			
-232,926,613	-8,061,953	-240,988,566	Total Long Term Debts	-206,159,453	-34,829,113	-240,988,566
			DEFFERED CREDITS AND OTHER LIAB			
			Professional Liab Risk			
			Deferred Incomes Taxes			
93,008	-1,788	91,220	Long-Term Obligations	94,674	-3,454	91,220
93,008	-1,788	91,220	Total Other Liabilities & Def	94,674	-3,454	91,220
			EQUITY			
1,000	0	1,000	Common Stock - par value	1,000	0	1,000
23,562,553	0	23,562,553	Capital in Excess of par value	23,562,553	0	23,562,553
246,490,851	0	246,490,851	Retained Earnings - current yr	291,765,889	0	291,765,889
36,703,688	8,571,339	45,275,027	Net Income Current Year			
			Distributions			
			Other Equity			
306,758,092	8,571,339	315,329,431	Total Equity	284,766,040	30,563,407	315,329,447
84,194,785	2,871,635	87,066,420	Total Liabilities and Equity	88,254,835	-1,188,415	87,066,420

F00025 - SUMMIT MED CTR-TOT HOS OPS - S031

Dec - 2012

All Entities

3/11/2013 12:46:17 PM

Report ID: ALCFS008

Financial Statements - Income Statement

Month								Year to Date						
Actual	Budget	Bud Var	Var %	Prior Year	PY Var	Var %		Actual	Budget	Bud Var	Var %	Prior Year	PY Var	Var %
							REVENUES							
6,532	6,412	120	1.88%	6,192	340	5.49%	Inpatient Revenue Routine Services	70,651	69,606	1,045	1.50%	62,552	8,098	12.95%
31,782	30,907	875	2.83%	30,930	852	2.76%	Inpatient Revenue Ancillary Services	349,226	337,499	11,727	3.47%	309,122	40,104	12.97%
38,315	37,319	996	2.67%	37,122	1,193	3.21%	Inpatient Gross Revenue	419,876	407,105	12,771	3.14%	371,674	48,202	12.97%
29,710	27,061	2,649	9.79%	26,716	2,994	11.21%	Outpatient Gross Revenue	335,856	309,225	26,631	8.61%	283,735	52,121	18.37%
68,025	64,380	3,644	5.66%	63,838	4,187	6.56%	Total Patient Revenue	755,732	716,330	39,402	5.50%	655,409	100,323	15.31%
81	89	(7)	-8.35%	86	(5)	-5.55%	Other Revenue	1,141	1,101	40	3.63%	1,088	52	4.79%
68,106	64,469	3,637	5.64%	63,924	4,182	6.54%	Gross Revenue	756,873	717,431	39,442	5.50%	656,497	100,376	15.29%
							DEDUCTIONS							
15,797	16,919	(1,122)	-6.63%	14,996	800	5.34%	Total CY CA - Medicare (1,2)	185,434	186,175	(741)	-0.40%	166,932	18,502	11.08%
136	223	(87)	-39.14%	85	50	59.01%	Total CY CA - Medicaid (3)	954	2,482	(1,529)	-61.58%	1,697	(743)	-43.79%
625	674	(50)	-7.35%	806	(181)	-22.49%	Total CY CA - Champus (6)	6,137	7,489	(1,351)	-18.04%	6,740	(602)	-8.94%
(1,175)		(1,175)		(67)	(1,108)	1,652.21%	Prior Year Contractuals	(1,958)	(909)	(1,049)	-115.39%	(1,281)	(677)	-52.82%
29,814	26,772	3,042	11.36%	28,237	1,578	5.59%	Total CY CA - Mgd Care (7,8,9,12,13)	323,353	296,550	26,803	9.04%	272,657	50,696	18.59%
257	356	(99)	-27.91%	859	(603)	-70.12%	Charity	5,391	4,021	1,370	34.08%	3,824	1,567	40.99%
1,454	1,873	(420)	-22.40%	1,695	(241)	-14.24%	Bad Debt	18,488	14,609	3,879	26.56%	13,078	5,410	41.37%
4,855	4,240	615	14.50%	2,591	2,264	87.39%	Other Deductions	52,987	46,515	6,472	13.91%	39,800	13,187	33.13%
51,762	51,057	704	1.38%	49,202	2,560	5.20%	Total Revenue Deductions (incl Bad Debt)	590,786	556,931	33,856	6.08%	503,446	87,340	17.35%
16,344	13,412	2,933	21.87%	14,722	1,622	11.02%	Cash Revenue	166,087	160,500	5,587	3.48%	153,051	13,036	8.52%
							OPERATING EXPENSES							
3,943	3,740	203	5.42%	3,770	172	4.57%	Salaries and Wages	44,152	43,522	630	1.45%	42,614	1,538	3.61%
8	21	(13)	-62.61%		8		Contract Labor	138	247	(110)	-44.37%		138	
935	1,009	(74)	-7.35%	958	(23)	-2.43%	Employee Benefits	12,542	12,004	538	4.48%	11,539	1,003	8.69%
1,926	2,198	(272)	-12.37%	2,450	(524)	-21.38%	Supply Expense	24,857	25,729	(872)	-3.39%	25,181	(324)	-1.29%
278	346	(68)	-19.62%	241	37	15.29%	Professional Fees	3,778	4,116	(339)	-8.23%	2,316	1,462	63.10%
1,411	1,294	116	8.98%	1,204	207	17.19%	Contract Services	15,868	14,931	937	6.28%	13,570	2,298	16.94%
308	319	(11)	-3.44%	330	(22)	-6.58%	Repairs and Maintenance	3,742	3,839	(97)	-2.52%	3,455	287	8.30%
142	138	4	3.25%	137	6	4.30%	Rents and Leases	1,712	1,650	61	3.72%	1,911	(199)	-10.43%
172	166	6	3.63%	170	2	1.11%	Utilities	2,035	2,241	(206)	-9.18%	2,079	(44)	-2.10%
(242)	(218)	(24)	-11.07%	(356)	114	32.03%	Insurance	2,281	2,306	(25)	-1.08%	1,772	508	28.68%
							Investment Income							
(6)	97	(103)	-106.35%	94	(100)	-106.58%	Non-Income Taxes	1,339	1,168	171	14.65%	1,041	298	28.62%
466	204	262	128.55%	272	194	71.04%	Other Operating Expense	2,349	2,675	(326)	-12.17%	2,564	(214)	-8.35%
9,341	9,315	26	0.28%	9,271	70	0.76%	Cash Expense	114,792	114,427	364	0.32%	108,041	6,751	6.25%
7,003	4,096	2,907	70.96%	5,451	1,552	28.48%	EBITDA	51,295	46,073	5,222	11.34%	45,010	6,285	13.96%
							CAPITAL AND OTHER COSTS							
626	596	30	5.00%	626	0	0.03%	Depreciation & Amortization	7,489	7,478	12	0.16%	7,017	472	6.73%
							Other Non-Operating Expenses							
(1,008)	(2,303)	1,295	56.22%	7,856	(8,864)	-112.83%	Interest Expense	(11,171)	(25,125)	13,955	55.54%	(9,907)	(1,263)	-12.75%
(1,186)	980	(2,167)	-221.00%	(1,111)	(75)	-6.76%	Mgmt Fees and Markup Cost	9,701	11,766	(2,064)	-17.54%	10,589	(887)	-8.38%
							Minority Interest							
(1,568)	(726)	(842)	-116.02%	7,371	(8,939)	-121.28%	Total Capital and Others	6,020	(5,882)	11,902	202.35%	7,699	(1,679)	-21.80%
8,571	4,822	3,749	77.74%	(1,920)	10,491	546.50%	Pretax Income	45,275	51,955	(6,680)	-12.86%	37,312	7,963	21.34%
							TAXES ON INCOME							
							Federal Income Taxes							
							State Income Taxes							
							Total Taxes on Income							
8,571	4,822	3,749	77.74%	(1,920)	10,491	546.50%	Net Income	45,275	51,955	(6,680)	-12.86%	37,312	7,963	21.34%

- News Releases
- Webcasts / Presentations
- Corporate Governance
- SEC Filings
- Annual Reports
- Contact Us / Request Information
- FAQ's
- Glossary

Print Version

HCA Reports Third Quarter 2012 Results

NASHVILLE, Tenn.--(BUSINESS WIRE)--Nov. 1, 2012-- HCA Holdings, Inc. (NYSE: HCA) today announced financial and operating results for the third quarter ended September 30, 2012.

Key third quarter metrics (all percentage changes compare 3Q 2012 to 3Q 2011 unless noted):

- Revenues increased 11.1 percent to $8.062 billion
- Net income attributable to HCA Holdings, Inc. totaled $360 million, or $0.78 per diluted share
- Adjusted EBITDA increased 8.6 percent to $1.533 billion
- Cash flows from operations declined to $655 million due primarily to changes in working capital items and higher tax payments
- Same facility equivalent admissions increased 2.6 percent while same facility admissions increased 2.1 percent
- Same facility revenue per equivalent admission increased 0.7 percent

HCA Chairman and Chief Executive Officer, Richard M. Bracken, said, "We are pleased with the results of the third quarter. Although we remain in a challenging economic environment, we remain focused on clinical and operational initiatives that position the Company for future changes in the healthcare industry."

Revenues in the third quarter totaled $8.062 billion, compared to $7.258 billion in the third quarter of 2011. Third quarter revenue growth was primarily driven by increased volume and the consolidation of our HealthONE venture, which was accounted for under the equity method for periods prior to November 2011. Equivalent admissions increased 8.3 percent, while admissions increased 7.0 percent.

Same facility equivalent admissions increased 2.6 percent in the third quarter of 2012 compared to the prior year period, while same facility admissions increased 2.1 percent. Same facility emergency room visits increased 7.4 percent in the third quarter of 2012 compared to the prior year period.

Revenue per equivalent admission increased 2.5 percent in the third quarter of 2012, primarily reflecting a continuing shift in service and payer mix. The Company's operating expense per equivalent admission increased 3.1 percent from the prior

year's third quarter (2.0 percent on a same facility basis). During the third quarter of 2012, salaries and benefits, supplies and other operating expenses totaled $6.666 billion, or 82.7 percent of revenues, compared to $5.965 billion, or 82.1 percent of revenues, in the third quarter of 2011.

Adjusted EBITDA for the third quarter of 2012 increased 8.6 percent to $1.533 billion compared to $1.412 billion in the prior year period. Adjusted EBITDA is a non-GAAP financial measure. A table providing supplemental information on Adjusted EBITDA and reconciling net income attributable to HCA Holdings, Inc. to Adjusted EBITDA is included in this release.

Net income attributable to HCA Holdings, Inc. totaled $360 million, or $0.78 per diluted share, compared to $61 million, or $0.11 per diluted share, in the third quarter of 2011. Results for the third quarter of 2011 include pretax losses on retirement of debt of $406 million, or $0.49 per diluted share. The effective tax rate for the third quarter of 2011 was favorably impacted by the finalization of settlements for the 1997 through 2001 tax years. These settlements resulted in a reduction to interest expense related to taxing authority examinations of $66 million pretax, or $0.08 per diluted share. (All "per diluted share" disclosures are based upon amounts net of the applicable income taxes.)

Nine Months Ended September 30, 2012

Revenues for the nine months ended September 30, 2012 totaled $24.579 billion compared to $21.913 billion in the same period of 2011. Net income attributable to HCA Holdings, Inc. was $1.291 billion, or $2.81 per diluted share, compared to $530 million, or $1.04 per diluted share, for the first nine months of 2011. Results for the nine months ended September 30, 2011 include pretax losses on retirement of debt of $481 million, or $0.60 per diluted share, and a pretax charge for the termination of a management agreement of $181 million, or $0.29 per diluted share.

Balance Sheet and Cash Flow

As of September 30, 2012, HCA Holdings, Inc.'s balance sheet reflected cash and cash equivalents of $472 million, total debt of $26.933 billion, and total assets of $27.302 billion. During the third quarter of 2012, capital expenditures totaled $484 million, excluding acquisitions. Net cash provided by operating activities in the third quarter of 2012 totaled $655 million compared to $880 million in the prior year's third quarter. The reduction in cash flows from operating activities was primarily due to reductions of $145 million from changes in working capital items and $107 million from higher income taxes.

Special Cash Dividend

On October 23, 2012, the Board of Directors approved a special cash dividend of $2.50 per share to be paid to stockholders of record as of November 2, 2012 with a payment date of November 16, 2012. The dividend is expected to be funded through borrowings under the Company's credit facilities.

As of September 30, 2012, HCA operated 162 hospitals and 112 freestanding surgery centers.

Earnings Conference Call

HCA will host a conference call for investors at 9:00 a.m. Central Daylight Time today. All interested investors are invited to access a live audio broadcast of the call via webcast. The broadcast also will be available on a replay basis beginning this

118

Diluted earnings per share	**$0.78**	$0.11
Shares used in computing diluted earnings per share (000)	**459,515**	527,515
Comprehensive income (loss) attributable to HCA Holdings, Inc.	**$369**	($24)

HCA Holdings, Inc.

Condensed Consolidated Comprehensive Income Statements

For the Nine Months Ended September 30, 2012 and 2011

(Dollars in millions, except per share amounts)

	2012		2011	
	Amount	**Ratio**	Amount	Ratio
Revenues before provision for doubtful accounts	**$ 27,245**		$ 24,077	
Provision for doubtful accounts	**2,666**		2,164	
Revenues	**24,579**	**100.0 %**	21,913	100.0 %
Salaries and benefits	**11,224**	**45.7**	9,948	45.4
Supplies	**4,216**	**17.2**	3,833	17.5
Other operating expenses	**4,496**	**18.2**	4,017	18.3
Electronic health record incentive income	**(256)**	**(1.0)**	(90)	(0.4)
Equity in earnings of affiliates	**(26)**	**(0.1)**	(217)	(1.0)
Depreciation and amortization	**1,254**	**5.1**	1,078	4.9
Interest expense	**1,336**	**5.4**	1,572	7.2
Losses (gains) on sales of facilities	(4)	-	3	-
Losses on retirement of debt	-	-	481	2.2
Termination of management agreement	-	-	181	0.8
	22,240	**90.5**	20,806	94.9
Income before income taxes	**2,339**	**9.5**	1,107	5.1
Provision for income taxes	**760**	**3.1**	307	1.5

119

Net income	**1,579**	**6.4**	800	3.6
Net income attributable to noncontrolling interests	**288**	**1.1**	270	1.2
Net income attributable to HCA Holdings, Inc.	**$ 1,291**	**5.3**	$ 530	2.4
Diluted earnings per share	**$ 2.81**		$ 1.04	
Shares used in computing diluted earnings per share (000)	**458,822**		509,583	
Comprehensive income attributable to HCA Holdings, Inc.	**$ 1,291**		$ 534	

HCA Holdings, Inc.

Supplemental Non-GAAP Disclosures

Operating Results Summary

(Dollars in millions, except per share amounts)

	Third Quarter		For the Nine Months Ended September 30,	
	2012	**2011**	**2012**	**2011**
Revenues	**$ 8,062**	$ 7,258	24,579	$ 21,913
Net income attributable to HCA Holdings, Inc.	**$ 360**	$ 61	**$ 1,291**	$ 530
Losses (gains) on sales of facilities (net of tax)	**(5)**	1	**(3)**	4
Losses on retirement of debt (net of tax)	**-**	256	**-**	303
Termination of management agreement (net of tax)	**-**	-	**-**	149
Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement (a)	**355**	318	**1,288**	986
Depreciation and amortization	**417**	362	**1,254**	1,078
Interest expense	**446**	519	**1,336**	1,572
Provision for income taxes	**220**	128	**759**	516
Net income attributable to noncontrolling interests	**95**	85	**288**	270
Adjusted EBITDA (a)	**$ 1,533**	$ 1,412	**$ 4,925**	$ 4,422

Diluted earnings per share:				
Net income attributable to HCA Holdings, Inc.	**$ 0.78**	$ 0.11	**$ 2.81**	$ 1.04
Losses (gains) on sales of facilities	**(0.01)**	-	-	0.01
Losses on retirement of debt	-	0.49	-	0.60
Termination of management agreement	-	-	-	0.29
Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement (a)	**$ 0.77**	$ 0.60	**$ 2.81**	$ 1.94
Shares used in computing diluted earnings per share (000)	459,515	527,515	458,822	509,583

(a) Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA should not be considered as measures of financial performance under generally accepted accounting principles ("GAAP"). We believe net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are important measures that supplement discussions and analysis of our results of operations. We believe it is useful to investors to provide disclosures of our results of operations on the same basis used by management. Management relies upon net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA as the primary measures to review and assess operating performance of its hospital facilities and their management teams.

Management and investors review both the overall performance (including; net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and GAAP net income attributable to HCA Holdings, Inc.) and operating performance (Adjusted EBITDA) of our health care facilities. Adjusted EBITDA and the Adjusted EBITDA margin (Adjusted EBITDA divided by revenues) are utilized by management and investors to compare our current operating results with the corresponding periods during the previous year and to compare our operating results with other companies in the health care industry. It is reasonable to expect that losses (gains) on sales of facilities and losses on retirement of debt will occur in future periods, but the amounts recognized can vary significantly from period to period, do not directly relate to the ongoing operations of our health care facilities and complicate period comparisons of our results of operations and operations comparisons with other health care companies.

Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are not measures of financial performance under GAAP, and should not be considered as alternatives to net income attributable to HCA Holdings, Inc. as a measure of operating

performance or cash flows from operating, investing and financing activities as a measure of liquidity. Because net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA are not measurements determined in accordance with GAAP and are susceptible to varying calculations, net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, losses on retirement of debt and termination of management agreement and Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures presented by other companies.

HCA Holdings, Inc.

Condensed Consolidated Balance Sheets

(Dollars in millions)

	September 30, 2012	June 30, 2012	December 31, 2011
ASSETS			
Current assets:			
Cash and cash equivalents	$ 472	$ 518	$ 373
Accounts receivable, net	4,598	4,485	4,533
Inventories	1,052	1,055	1,054
Deferred income taxes	322	323	594
Other	828	756	679
Total current assets	7,272	7,137	7,233
Property and equipment, at cost	29,145	28,742	28,075
Accumulated depreciation	(16,185)	(15,896)	(15,241)
	12,960	12,846	12,834
Investments of insurance subsidiaries	473	495	548
Investments in and advances to affiliates	103	102	101
Goodwill and other intangible assets	5,460	5,431	5,251
Deferred loan costs	266	281	290
Other	768	840	641
	$ 27,302	$ 27,132	$ 26,898

LIABILITIES AND STOCKHOLDERS' DEFICIT			
Current liabilities:			
Accounts payable	$ 1,585	$ 1,517	$ 1,597
Accrued salaries	1,027	970	965
Other accrued expenses	1,498	1,651	1,585
Long-term debt due within one year	1,751	1,309	1,407
Total current liabilities	5,861	5,447	5,554
Long-term debt	25,182	25,732	25,645
Professional liability risks	962	1,039	993
Income taxes and other liabilities	1,860	1,857	1,720
EQUITY (DEFICIT)			
Stockholders' deficit attributable to HCA Holdings, Inc.	(7,859)	(8,243)	(8,258)
Noncontrolling interests	1,296	1,300	1,244
Total deficit	(6,563)	(6,943)	(7,014)
	$ 27,302	$ 27,132	$ 26,898

HCA Holdings, Inc.

Condensed Consolidated Statements of Cash Flows

For the Nine Months Ended September 30, 2012 and 2011

(Dollars in millions)

	2012	2011
Cash flows from operating activities:		
Net income	**$ 1,579**	$ 800
Adjustments to reconcile net income to net cash provided by operating activities:		
Changes in operating assets and liabilities	**(2,923)**	(2,336)
Provision for doubtful accounts	**2,666**	2,164
Depreciation and amortization	**1,254**	1,078
Income taxes	**250**	348

payments.

Year Ended December 31, 2011

Revenues for the year ended December 31, 2011 totaled $29.682 billion compared to $28.035 billion in 2010. Net income attributable to HCA Holdings, Inc. in 2011 was $2.465 billion, or $4.97 per diluted share, compared to $1.207 billion, or $2.76 per diluted share, for 2010. Results for the year ended December 31, 2011 include a pretax gain on the acquisition of a controlling interest in an equity investment of $1.522 billion, or $2.87 per diluted share, pretax gains on sales of facilities of $142 million, or $0.16 per diluted share, pretax losses on the retirement of debt of $481 million, or $0.61 per diluted share, and a pretax charge for termination of management agreement of $181 million, or $0.30 per diluted share. Results for the year ended December 31, 2010 include pretax impairments of long-lived assets of $123 million, or $0.18 per diluted share, and pretax gains on sales of facilities of $4 million, or $0.01 per diluted share. Adjusted EBITDA for 2011 totaled $6.061 billion compared to $5.868 billion in 2010.

Balance Sheet and Cash Flow

As of December 31, 2011, HCA Holdings, Inc.'s balance sheet reflected cash and cash equivalents of $373 million, total debt of $27.052 billion, and total assets of $26.898 billion. During the fourth quarter, capital expenditures totaled $509 million, excluding acquisitions, compared to $465 million in the previous year's fourth quarter. HCA's debt-to-Adjusted EBITDA ratio at December 31, 2011 was 4.46x compared to 4.81x at December 31, 2010. Net cash provided by operating activities totaled $1.387 billion compared to $534 million in the fourth quarter of 2010. The increase in cash flows from operating activities was primarily due to improved cash flows of $467 million related to income taxes and $388 million related to working capital items.

Special Dividend

HCA also today announced that its Board of Directors has approved a special cash dividend of $2.00 per share to be paid to shareholders of record as of February 16, 2012 with a payment date of February 29, 2012. The dividend is expected to be funded through existing cash and borrowings under the Company's credit facilities.

"We believe that a special dividend provides liquidity to our shareholders while not affecting our ability to invest in our markets or impair our acquisition strategy. Also, the impact of this dividend on the Company's leverage will be modest," stated R. Milton Johnson, HCA President and Chief Financial Officer.

2012 Guidance

Today, HCA issued the following estimated guidance for 2012:

	2011	2012 RANGE
Revenues (1)	$29.682 billion	$32 to $33 billion
Adjusted EBITDA	$6.061 billion	$6.20 to $6.45 billion
Adjusted EPS (diluted) (2)	$2.85	$3.35 to $3.55

Equity in earnings of affiliates	(41)	(0.5)	(72)	(1.0)
Depreciation and amortization	387	5.0	359	5.0
Interest expense	465	6.0	526	7.3
Gains on sales of facilities	(145)	(1.9)	(6)	(0.1)
Gain on acquisition of controlling interest in equity investment	(1,522)	(19.6)	-	-
Impairments of long-lived assets	-	-	4	0.1
	5,315	68.4	6,597	92.1
Income before income taxes	2,454	31.6	564	7.9
Provision for income taxes	412	5.3	170	2.4
Net income	2,042	26.3	394	5.5
Net income attributable to noncontrolling interests	107	1.4	111	1.5
Net income attributable to HCA Holdings, Inc.	$1,935	24.9	$283	4.0
Diluted earnings per share	$4.25		$0.65	
Shares used in computing diluted earnings per share (000)	455,460		437,568	

HCA Holdings, Inc.

Condensed Consolidated Income Statements

For the Years Ended December 31, 2011 and 2010

(Dollars in millions, except per share amounts)

	2011		2010	
	Amount	Ratio	Amount	Ratio
Revenues before provision for doubtful accounts	$32,506		$30,683	
Provision for doubtful accounts	2,824		2,648	
Revenues	29,682	100.0%	28,035	100.0%

Salaries and benefits	**13,440**	**45.3**	12,484	44.5
Supplies	**5,179**	**17.4**	4,961	17.7
Other operating expenses	**5,470**	**18.5**	5,004	17.9
Electronic health record incentive income	**(210)**	**(0.7)**	-	-
Equity in earnings of affiliates	**(258)**	**(0.9)**	(282)	(1.0)
Depreciation and amortization	**1,465**	**4.9**	1,421	5.0
Interest expense	**2,037**	**6.9**	2,097	7.5
Gains on sales of facilities	**(142)**	**(0.5)**	(4)	-
Gain on acquisition of controlling interest in equity investment	**(1,522)**	**(5.1)**	-	-
Impairments of long-lived assets	**-**	**-**	123	0.4
Losses on retirement of debt	**481**	**1.6**	-	-
Termination of management agreement	**181**	**0.6**	-	-
	26,121	**88.0**	25,804	92.0
Income before income taxes	**3,561**	**12.0**	2,231	8.0
Provision for income taxes	**719**	**2.4**	658	2.4
Net income	**2,842**	**9.6**	1,573	5.6
Net income attributable to noncontrolling interests	**377**	**1.3**	366	1.3
Net income attributable to HCA Holdings, Inc.	**$2,465**	**8.3**	$1,207	4.3
Diluted earnings per share	**$4.97**		$2.76	
Shares used in computing diluted earnings per share (000)	**495,943**		437,347	

HCA Holdings, Inc.

Supplemental Non-GAAP Disclosures

Operating Results Summary

(Dollars in millions, except per share amounts)

management agreement and Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures presented by other companies.

HCA Holdings, Inc.

Condensed Consolidated Balance Sheets

(Dollars in millions)

	December 31, 2011	September 30, 2011	December 31, 2010
ASSETS			
Current assets:			
Cash and cash equivalents	$373	$359	$411
Accounts receivable, net	4,533	3,925	3,832
Inventories	1,054	891	897
Deferred income taxes	594	643	931
Other	679	875	848
Total current assets	7,233	6,693	6,919
Property and equipment, at cost	28,075	26,647	25,641
Accumulated depreciation	(15,241)	(15,002)	(14,289)
	12,834	11,645	11,352
Investments of insurance subsidiaries	548	545	642
Investments in and advances to affiliates	101	837	869
Goodwill and other intangible assets	5,251	2,701	2,693
Deferred loan costs	290	297	374
Other	641	1,038	1,003
	$26,898	$23,756	$23,852

LIABILITIES AND STOCKHOLDERS' DEFICIT

Current liabilities:			
Accounts payable	$1,597	$1,334	$1,537
Accrued salaries	965	876	895
Other accrued expenses	1,585	1,336	1,245
Long-term debt due within one year	1,407	725	592
Total current liabilities	5,554	4,271	4,269
Long-term debt	25,645	25,871	27,633
Professional liability risks	993	993	995
Income taxes and other liabilities	1,720	1,683	1,608
Total liabilities	33,912	32,818	34,505
Equity securities with contingent redemption rights	-	-	141
EQUITY (DEFICIT)			
HCA Holdings, Inc. stockholders' deficit	(8,258)	(10,194)	(11,926)
Noncontrolling interests	1,244	1,132	1,132
Total deficit	(7,014)	(9,062)	(10,794)
	$26,898	$23,756	$23,852

HCA Holdings, Inc.

Condensed Consolidated Statements of Cash Flows

For the Years Ended December 31, 2011 and 2010

(Dollars in millions)

	2011	2010
Cash flows from operating activities:		
Net income	**$2,842**	$1,573
Adjustments to reconcile net income to net cash provided by operating activities:		
Changes in operating assets and liabilities	**(2,953)**	(2,847)
Provision for doubtful accounts	**2,824**	2,648
Depreciation and amortization	**1,465**	1,421
Income taxes	**912**	27

C, Orderly Development--7(C)
Licensing & Accreditation Inspections

The Joint Commission

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Organization Identification Number: 7806

Program(s)	**Survey Date(s)**
Hospital Accreditation	05/22/2012-05/25/2012

Executive Summary

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

DIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	EC.02.05.07	EP6
	MM.04.01.01	EP13
	MM.05.01.01	EP8
	NPSG.03.04.01	EP2

INDIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP11
	EC.02.03.01	EP10
	EC.02.05.01	EP4
	EC.02.05.09	EP3
	EC.02.06.01	EP13
	LS.02.01.20	EP29
	LS.02.01.50	EP12
	MM.03.01.01	EP3,EP6
	RC.01.01.01	EP19
	RI.01.03.01	EP5

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)(2)	A-0406	HAP - MM.04.01.01/EP13	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(2)(v)	A-0466	HAP - RI.01.03.01/EP5	Standard

CoP: §482.25 **Tag:** A-0490 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)(2)(i)	A-0502	HAP - MM.03.01.01/EP6, EP3	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.05.07/EP6	Standard
§482.41(c)(4)	A-0726	HAP - EC.02.06.01/EP13	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP29, LS.02.01.50/EP12	Standard

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01

Standard Text: The hospital manages risks related to hazardous materials and waste.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

11. For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and material safety data sheets required by law and regulation. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 11
Observed in Environment of Care Session at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
There was no written documentation that the individual, that had signed the generator's certification on the uniform hazardous waste manifest for pharmaceutical waste, had received US Department of Transportation training for the safe packaging and transportation of hazardous materials.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.01

Standard Text: The hospital manages fire risks.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

10. The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire's point of origin, including when and how to sound fire alarms, how to contain smoke and fire, how to use a fire extinguisher, and how to evacuate to areas of refuge. (See also EC.02.03.03, EP 5; EC.03.01.01, EP 2; and HR.01.04.01, EP 2)
Note: For additional guidance, see NFPA 101, 2000 edition (Sections 18/19.7.1 and 18/19.7.2). 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 10
Observed in Environment of Care Session at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
The written fire response plan did not describe how to use a fire extinguisher.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.01

Standard Text: The hospital manages risks associated with its utility systems.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. The hospital identifies, in writing, the intervals for inspecting, testing, and maintaining all operating components of the utility systems on the inventory, based on criteria such as manufacturers' recommendations, risk levels, or hospital experience. (See also EC.02.05.05, EPs 3-5)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Environment of Care Session at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
There was documentation that the hospital had identified, in writing, the interval for inspecting, testing, and maintaining the air handling equipment for air exchange rates and air pressure relationships in those areas requiring specific air exchange rates and pressure relationships as annually. However, air exchange rates had not been verified since 2008.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.07

Standard Text: The hospital inspects, tests, and maintains emergency power systems.
Note: This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

6. Twelve times a year, at intervals of not less than 20 days and not more than 40 days, the hospital tests all automatic transfer switches. The completion date of the tests is documented.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 6
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that the transfer switch, that serves the fire pump, had been tested monthly. It had not been part of the monthly generator load test. It did not appear on the list of automatic transfer switches on the monthly generator test form.

The Joint Commission
Findings

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.09

Standard Text: The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
The main supply valves for oxygen, nitrogen, nitrous oxide, and vacuum were not labeled to identify what the valves controlled. The valves were labeled during the survey.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.06.01

Standard Text: The hospital establishes and maintains a safe, functional environment. Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

13. The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 13
§482.41(c)(4) - (A-0726) - (4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The 2008 ventilation study indicated that Delivery rooms one and two did not meet minimum air exchange rates. There was no documentation that the deficiency had been corrected.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

29. Stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge. The signs are placed 5 feet above the floor landing in a position that is easily visible when the door is open or closed. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.2.5.4)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 29
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the North stairwell, did not identify the top and bottom and the story of exit discharge.

Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the South stairwell, did not identify the top and bottom and the story of exit discharge.

Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the East stairwell, did not identify the top and bottom and the story of exit discharge.

Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the West stairwell, did not identify the top and bottom and the story of exit discharge.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.50

Standard Text: The hospital provides and maintains building services to protect individuals from the hazards of fire and smoke.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

12. The hospital meets all other Life Safety Code building service requirements related to NFPA 101-2000: 18/19.5. 

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 12
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that all elevators equipped with fire fighter service had a monthly operation test, in February 2012, with a written record of the findings made and kept on the premises as required by NFPA 101-19.5.3 and NFPA 101 - 9.4.6.

Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that all elevators equipped with fire fighter service had a monthly operation test, in March 2012, with a written record of the findings made and kept on the premises as required by NFPA 101-19.5.3 and NFPA 101 - 9.4.6.

Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that all elevators equipped with fire fighter service had a monthly operation test, in April 2012, with a written record of the findings made and kept on the premises as required by NFPA 101-19.5.3 and NFPA 101 - 9.4.6.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.03.01.01
Standard Text: The hospital safely stores medications.
Primary Priority Focus Area: Medication Management

Element(s) of Performance:

3. The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation. 
Note: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Scoring Category : A
Score : Insufficient Compliance

6. The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.25(b)(2)(i) - (A-0502) - (2)(i) All drugs and biologicals must be kept in a secure area, and locked when appropriate.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Outpatient Center (3901 Central Pike, Hermitage, TN) site for the Hospital deemed service.
Oral contrast (Readi-Cat) was stored in an unlocked refrigerator in the control area of the CT and MRI suite. On the weekends when the area was closed, the temperature of the refrigerator was not monitored to ensure that the contrast was stored according to manufacturer's recommendations. During the survey a lock was put on the refrigerator.

EP 6
§482.25(b)(2)(i) - (A-0502) - (2)(i) All drugs and biologicals must be kept in a secure area, and locked when appropriate.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The hospital's policy for the disposal of used duragesic patches required that the disposal be witnessed and documented by a second nurse. However, the patches were disposed of in a 16 gallon sharps container with an opening that would allow someone to reach in and remove the patch. The sharps containers were located in the soiled utility room that was locked, but accessible to other personnel including non-licensed personnel. The documentation of the disposal by two nurses was done in the pyxis machine located in another room on the unit. This method of disposal increased the potential risk of diversion after the patch was discarded.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.04.01.01
Standard Text: Medication orders are clear and accurate.
Primary Priority Focus Area: Medication Management

Element(s) of Performance:

13. The hospital implements its policies for medication orders.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 13
§482.23(c)(2) - (A-0406) - (2) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under §482.12(c).
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
An order was written for a propofol sedation drip for a 78 year old patient who was placed on a ventilator. The order did not include the RASS goal for the sedation as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
A 52 year old male admitted with diabetes received two units of Humalog insulin and there was no documentation in the record that the medication was double checked by a second RN as required by hospital policy.

Observed in Medication Management Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
During a high risk drug tracer, a patient was noted to have heparin protocol orders to increase the heparin drip if the PTT decreased to less than 46. The patient's PTT decreased to 38 on 5/20/2012 and heparin drip was not adjusted as required by protocol.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.05.01.01
Standard Text: A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.
Primary Priority Focus Area: Medication Management

Element(s) of Performance:

8. All medication orders are reviewed for the following: Therapeutic duplication.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 8
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
On a post c/section patient the anesthesiologist ordered on a preprinted order sheet three prn medications for nausea: Zofran, Reglan, and a Scopolamine patch. The order did not specify which medication to give for a specific circumstance. It was not clear as to which medication(s) the nurse should give or in which order.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
A second patient on 5th Surgical Floor was noted to have prn orders for both Zofran and Reglan for post-operative nausea with no indication of which drug to give or whether to give both drugs simultaneously. The orders were not clarified for therapeutic duplication.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.03.04.01

Standard Text: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
Note: Medication containers include syringes, medicine cups, and basins.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Medication Management Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
During the Medication Management Tracer in the pharmacy, seven unlabeled syringes containing medications were noted to be unattended under the hood used for the preparation of TPN. Each syringe was carefully lined up next to a vial of medication. The medications were not labeled when they were drawn-up as required by regulation.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
A progress note written on a 56 year old patient admitted with fluid overload, shortness of breath and hypertension was not dated or timed by the physician as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
A telephone order was authenticated without a date and time as required by CMS on a 56 year old male patient.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The immediate post procedure note for a 78 year old patient who had a incision and drainage of an infected finger was not timed as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The post procedure note for the placement of a vascatheter for dialysis access was not timed as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Several entries, eg treatment plan, initial evaluation, in the outpatient rehab charts were not timed as required by the hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Medication reconciliation orders were not dated or timed by the ordering physician on an obstetrical patient.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Primary Priority Focus Area: Rights & Ethics

Element(s) of Performance:

5. The hospital's written policy describes how informed consent is documented in the patient record.
Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
§482.24(c)(2)(v) - (A-0466) - [All records must document the following, as appropriate:]

(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Hospital Informed Consent/Consent for Treatment policy does not describe how informed consent is documented in the medical record.

Patient-Centered Communication Standards

The Joint Commission recognizes that hospitals may require additional time to meet the requirements of the new and revised patient-centered communication standards. As such, the Joint Commission is providing a free monograph, Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered care: A Roadmap for Hospitals, on its website, jointcommission.org/patientsafety/hlc to inspire hospitals to integrate concepts from the communication, cultural competence, and patient- and family-centered care fields into their organizations. Throughout 2011, although surveyors will evaluate compliance with these requirements, they will not generate a requirement for improvement and/or affect an organization's accreditation decision.

Chapter:	Provision of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	PC.02.01.21
Standard Text:	The hospital effectively communicates with patients when providing care, treatment, and services. Note: This standard will not affect the accreditation decision at this time.
Primary Priority Focus Area:	Information Management

Element(s) of Performance:

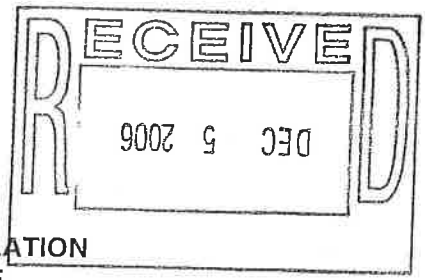
1. The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. (See also RC.02.01.01, EP 1) 
Note 1: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.
Note 2: This element of performance will not affect the accreditation decision at this time.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
The hospital documents the patient's primary language rather than the patient's preferred language for receiving or discussing health care information.

P: Colleen Patterson
cc: Tom Oglburn



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
MIDDLE TENNESSEE REGIONAL OFFICE
710 HART LANE, 1ST FLOOR
NASHVILLE, TENNESSEE 37247-0530
PHONE (615) 650-7100
FAX (615) 650-7101

December 1, 2006

Jeffrey Whitehorn, Administrator
Summit Medical Center
5655 Frist Blvd
Hermitage, TN 37076

Dear Mr. Whitehorn:

Enclosed is the statement of deficiencies developed as the result of the revisit on the state licensure survey of Summit Medical Center on November 30, 2006.

Please provide us with documentation to describe how and when these deficiencies will be corrected. This information should be received in our office within ten (10) calendar days after receipt of this letter. It is imperative that you assure correction of the cited deficiencies no later than sixty (60) days from the date of the initial survey. A follow-up visit may be conducted, if your allegation of correction is reasonable and convincing. Failure to provide an acceptable plan of correction could result in a referral to the Board of Licensing Health Care Facilities for whatever action they deem appropriate.

In order for your Plan of Correction (PoC) to be acceptable, it should address the following:

1. How you will correct the deficiency;
2. Who will be responsible for correcting the deficiency;
3. The date the deficiency will be corrected; and
4. How you will prevent the same deficiency from happening again.

Should you have any questions, or if there is any way this office may be of assistance, please do not hesitate to call.

Sincerely,

Nina Monroe

Nina Monroe, Regional Administrator
Middle Tennessee Regional Office

ENCLOSURE

NM/dv

Summit Medical Center

TRISTAR HEALTH SYSTEM℠

December 11, 2006

ATTN: Nina Monroe, Regional Administrator
State of Tennessee
Department of Health
Bureau of Health Licensure and Regulation
Middle Tennessee Regional Office
710 Hart Lane, 1st Floor
Nashville, TN 37247-0530

Dear Ms. Monroe:

Attached you will find our responses to the Statement of Deficiencies resulting from your State Licensure Survey of Summit Medical Center on November 30, 2006.

Please note that we are requesting a "Desk Review" of items noted on Statement of Deficiencies form. I have attached documentation and code references highlighted with pertinent information to assist with this review.

If there are any questions, please contact me at 615-316-3645.

Sincerely,

Ted Jones
Director of Operations and Facilities

TJ/ds

Cc: Tom Ozburn, COO
Colleen Patterson, Director of Quality Management

PRINTED: 12/01/2006
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{H 901}	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Statute is not met as evidenced by: Surveyor: 13846 Based on observation and inspection, it was determined the facility failed to comply with the life safety codes and the electrical codes. The findings included: On 11/30/06 at approximately 11:00 AM, inspection of the facility revealed the vent covers were dirty on the ground, first, second, third, fourth, fifth, sixth, and seventh floors revealed the vent covers were dirty. NFPA 01, 19.5.2.1 Inspection of the seventh floor biohazard room and the sixth floor soiled utility room revealed the electrical panels were blocked with equipment. NFPA 70, 110-26(a) Inspection of the imaging staff work room, and the men's dressing room by x-ray revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99. 9.6.3.2.1 Inspection of the corridors revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99, 9.6.3.2.1 Inspection of the lab office and the accounting	{H 901}	SEMI-ANNUAL VENT COVERS CLEANING PM TO START IMMEDIATELY AND COMPLETE BY END OF JANUARY. 1/30/2007 A RAIL TO PROVIDE PROPER CLEARANCES TO BE INSTALLED TO PREVENT ITEMS FROM BLOCKING PANELS. 1/19/2007 REQUEST "DESK REVIEW" OF THIS FINDING. REQUEST "DESK REVIEW" OF THIS FINDING.	

PRINTED: 12/01/2006
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{H 901}	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Statute is not met as evidenced by: Surveyor: 13846 Based on observation and inspection, it was determined the facility failed to comply with the life safety codes and the electrical codes. The findings included: On 11/30/06 at approximately 11:00 AM, inspection of the facility revealed the vent covers were dirty on the ground, first, second, third, fourth, fifth, sixth, and seventh floors revealed the vent covers were dirty. NFPA 01, 19.5.2.1 Inspection of the seventh floor biohazard room and the sixth floor soiled utility room revealed the electrical panels were blocked with equipment. NFPA 70, 110-26(a) Inspection of the imaging staff work room, and the men's dressing room by x-ray revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99. 9.6.3.2.1 Inspection of the corridors revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99, 9.6.3.2.1 Inspection of the lab office and the accounting	{H 901}	SEMI-ANNUAL VENT COVERS CLEANING PM TO START IMMEDIATELY AND COMPLETE BY END OF JANUARY. 1/30/2007 A RAIL TO PROVIDE PROPER CLEARANCES TO BE INSTALLED TO PREVENT ITEMS FROM BLOCKING PANELS. 1/19/2007 REQUEST "DESK REVIEW" OF THIS FINDING. REQUEST "DESK REVIEW" OF THIS FINDING.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: DIRECTOR OF FACILITIES & OPERATIONS — (X6) DATE: 12/11/06

PRINTED: 12/01/2006
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{H 901}	Continued From page 1 office on the ground floor revealed power strips connected in tandem. NFPA 70, 373-4 Inspection of the patient rooms second, third, fourth, fifth, sixth, and the seventh floors revealed the doors are not constructed to resist the passage of smoke. NFPA 101, 19.3.6.2 Inspection of the first and third floor smoking areas revealed no covered ashtrays. NFPA 101, 19.7.4(4)	{H 901}	THE POWER STRIP IN TANDEM WILL BE REMOVED SEE NOTE BELOW. REQUEST "DESK REVIEW" OF THIS FINDING. METAL CONTAINERS WITH SELF-CLOSING COVERS ARE BEING ORDERED TO COMPLY WITH NFPA 19.7.4(6) NOTE: STAFF HAS BEEN INSTRUCTED ON PROPER USE OF POWER STRIPS.	1/19/2007 1/19/2007

9.5.3.1.2 **Use.** Carts and hand trucks that are intended to be used in anesthetizing locations or cylinder and container storage rooms communicating with anesthetizing locations shall comply with the appropriate provisions of 13.4.1.

9.5.3.2 **Gas Equipment — Laboratory.** Gas appliances shall be of an approved design and installed in accordance with NFPA 54, *National Fuel Gas Code*. Shutoff valves shall be legibly marked to identify the material they control.

9.6 **Administration.**

9.6.1 **Policies.**

9.6.1.1 **Elimination of Sources of Ignition.**

9.6.1.1.1 Smoking materials (e.g., matches, cigarettes, lighters, lighter fluid, tobacco in any form) shall be removed from patients receiving respiratory therapy.

9.6.1.1.2* No sources of open flame, including candles, shall be permitted in the area of administration.

9.6.1.1.3* Sparking toys shall not be permitted in any patient care area.

9.6.1.1.4 Nonmedical appliances that have hot surfaces or sparking mechanisms shall not be permitted within oxygen delivery equipment or within the site of intentional expulsion.

9.6.1.2 **Misuse of Flammable Substances.**

9.6.1.2.1 Flammable or combustible aerosols or vapors, such as alcohol, shall not be administered in oxygen-enriched atmospheres (*see B.6.1.11*).

9.6.1.2.2 Oil, grease, or other flammable substances shall not be used on or in oxygen equipment.

9.6.1.2.3 Flammable and combustible liquids shall not be permitted within the site of intentional expulsion.

9.6.1.3 **Servicing and Maintenance of Equipment.**

9.6.1.3.1 Defective equipment shall be immediately removed from service.

9.6.1.3.2 Defective electrical apparatus shall not be used.

9.6.1.3.3 Areas designated for the servicing of oxygen equipment shall be clean, free of oil and grease, and not used for the repair of other equipment.

9.6.1.3.4 Service manuals, instructions, and procedures provided by the manufacturer shall be used in the maintenance of equipment.

9.6.1.3.5 A scheduled preventive maintenance program shall be followed.

9.6.2 **Gases in Cylinders and Liquefied Gases in Containers.**

9.6.2.1 **Transfilling Cylinders.**

(A) Mixing of compressed gases in cylinders shall be prohibited.

(B) Transfer of gaseous oxygen from one cylinder to another shall be in accordance with CGA Pamphlet P-2.5, *Transfilling of High Pressure Gaseous Oxygen to Be Used for Respiration*.

(C) Transfer of any gases from one cylinder to another in patient care areas of health care facilities shall be prohibited.

9.6.2.2 **Transferring Liquid Oxygen.** Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:

(1) The area is separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hr fire-resistive construction.
(2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.
(3) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.

9.6.2.2.1 Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, *Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration*, and adhering to those procedures.

9.6.2.2.2 The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, *Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities*.

9.6.2.3 **Ambulatory Patients.** Ambulatory patients on oxygen therapy shall be permitted access to all flame and smoke free areas within the health care facility.

9.6.3 **Use (Including Information and Warning Signs).**

9.6.3.1 **Labeling.**

9.6.3.1.1 Equipment listed for use in oxygen-enriched atmospheres shall be so labeled.

9.6.3.1.2 Oxygen-metering equipment and pressure-reducing regulators shall be conspicuously labeled:

OXYGEN — USE NO OIL

9.6.3.1.3 Flowmeters, pressure-reducing regulators, and oxygen-dispensing apparatus shall be clearly and permanently labeled, designating the gas or mixture of gases for which they are intended.

9.6.3.1.4 Apparatus whose calibration or function is dependent on gas density shall be labeled as to the proper supply gas gage pressure (psi/kPa) for which it is intended.

9.6.3.1.5 Oxygen-metering equipment, pressure-reducing regulators, humidifiers, and nebulizers shall be labeled with the name of the manufacturer or supplier.

9.6.3.1.6 Cylinders and containers shall be labeled in accordance with ANSI/CGA C-7, *Guide to the Preparation for Cautionary Labeling and Marking for Compressed Gas Containers*. Color coding shall not be utilized as a primary method of determining cylinder or container content.

9.6.3.1.7 All labeling shall be durable and withstand cleansing or disinfection.

9.6.3.2* **Signs.**

9.6.3.2.1 In health care facilities where smoking is not prohibited, precautionary signs readable from a distance of 1.5 m (5 ft) shall be conspicuously displayed wherever supplemental oxygen is in use and in aisles and walkways leading to that area; they shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.

9.6.3.2.2 In health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no-smoking language shall not be required.

9.6.3.2.3 The nonsmoking policies shall be strictly enforced.

Summit Medical Center
TriStar Health System

MANUAL: Environment of Care	**POLICY DESCRIPTION:** Smoking
PAGE: 1 of 2	**REPLACES POLICY DATED:** N/A
APPENDICES: N/A	**REVIEWED:** June 2006
EFFECTIVE DATE: February 1998	**SECTION NUMBER:** 1

PURPOSE:

To promote good health habits and provide a clean air environment for patients, visitors, employees, volunteers, and the medical staff.

POLICY:

There will be no smoking allowed in the interior of Summit Medical Center, its adjacent office buildings or Medical Center-owned vehicles by employees, visitors, patients or the medical staff.

PROCEDURE:

1. Patients
   A. Patients being admitted to Summit Medical Center will not be allowed to smoke in the interior of Summit Medical Center, its adjacent office buildings or Medical Center owned vehicles. Patients who must smoke must do so in the designated areas established in Section 4.

   B. Patients admitted to the Psychiatric Unit are permitted to smoke, on the smoking porch only when in the opinion of the psychiatrist failure to do so would adversely affect the effectiveness of therapeutic interventions and/or the therapeutic milieu of the patient. A physician's order is required.

   C. If a patient refuses to follow this policy, the patient will be reminded of the policy and it will be documented in the patient's chart in the progress notes. If the patient continues to be non-compliant, the physician will be notified and security will be contacted to witness the removal of smoking materials. Smoking materials will be returned to the patient at discharge.

2. Visitors
   A. Visitors will be allowed to smoke only in designated areas exterior to the hospital.

   B. If a visitor is found to be smoking in the interior of the Medical Center, he/she will be informed of Summit Medical Center's smoking policy, politely asked not to smoke inside the building, and directed to the nearest designated area.

   C. If a visitor refuses to cooperate, report the incident to Security for resolution.

3. Employees, Volunteers, Physicians and MOB Staff
   A. Employees, volunteers, physicians, and MOB staff will be allowed to smoke only in designated smoking areas outside the facility.

MANUAL: Environment of Care	POLICY DESCRIPTION: Smoking
PAGE: 2 of 2	

B. Any employee found to be smoking in the interior of the hospital or a non-designated area will be subject to disciplinary action up to and including termination.

C. Employees should be reminded that they are allowed a thirty minute lunch break. This break may be taken as a time to smoke in the designated areas outside the building, if so chosen by the employee.

4. Designated Smoking areas exterior to the Hospital and Medical Office Buildings
   A. Employees, physicians, and volunteers will be allowed to smoke in the courtyard by the employee entrance and the designated smoking area adjacent to the rear Imaging entrance for employees.

   B. Patients and visitors will be allowed to smoke at designated areas outside the rear Imaging Entrance, the Visitor and Patient entrance and the Same Day Surgery patio on First Floor.

   C. Ambulatory Surgery Center designated smoking area is adjacent to the receiving area.

APPROVALS:

A.19.3.5.4 The provisions of 19.3.5.4(6) and 19.3.5.4(7) are not intended to supplant NFPA 13, *Standard for the Installation of Sprinkler Systems*, which requires that residential sprinklers with more than a 5.6°C (10°F) difference in temperature rating not be mixed within a room. Currently there are no additional prohibitions in NFPA 13 on the mixing of sprinklers having different thermal response characteristics. Conversely, there are no design parameters to make practical the mixing of residential and other types of sprinklers.

A.19.3.5.6 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 46 cm (18 in.) below the sprinkler deflector; using 1.3-cm (½-in.) diagonal mesh or a 70 percent open weave top panel that extends 46 cm (18 in.) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, *Standard for the Installation of Sprinkler Systems* The test data that forms the basis of the NFPA 13 requirements is from fire tests with sprinkler discharge that penetrated a single privacy curtain.

A.19.3.6.1(3) A typical nurses' station would normally contain one or more of the following with associated furniture and furnishings:

(1) Charting area
(2) Clerical area
(3) Nourishment station
(4) Storage of small amounts of medications, medical equipment and supplies, clerical supplies, and linens
(5) Patient monitoring and communication equipment

A.19.3.6.1(6)(b) A fully developed fire (flashover) occurs if the rate of heat release of the burning materials exceeds the capability of the space to absorb or vent that heat. The ability of common lining (wall, ceiling, and floor) materials to absorb heat is approximately 0.07 kJ per m^2 (0.75 Btu per ft^2) of lining. The venting capability of open doors or windows is in excess of 1.95 kJ per m^2 (20 Btu per ft^2) of opening. In a fire that has not reached flashover conditions, fire will spread from one furniture item to another only if the burning item is close to another furniture item. For example, if individual furniture items have heat release rates of 525 kW per second (500 Btu per second) and are separated by 305 mm (12 in.) or more, the fire is not expected to spread from item to item, and flashover is unlikely to occur. *(See also the NFPA Fire Protection Handbook.)*

A.19.3.6.1(7) This provision permits waiting areas to be located across the corridor from each other, provided that neither area exceeds the 55.7-m^2 (600-ft^2) limitation.

A.19.3.6.2.2 The intent of the ½-hour fire resistance rating for corridor partitions is to require a nominal fire rating, particularly where the fire rating of existing partitions cannot be documented. Examples of acceptable partition assemblies would include, but are not limited to 1.3-cm (½-in.) gypsum board, wood lath and plaster, gypsum lath, or metal lath and plaster.

A.19.3.6.2.3 An architectural, exposed, suspended-grid acoustical tile ceiling with penetrating items such as sprinkler piping and sprinklers; ducted HVAC supply and return-air diffusers; speakers; and recessed lighting fixtures is capable of limiting the transfer of smoke.

A.19.3.6.2.5 Monolithic ceilings are continuous horizontal membranes composed of noncombustible or limited-combustible materials, such as plaster or gypsum board, with seams or cracks permanently sealed.

A.19.3.6.2.6 The purpose of extending a corridor wall above a lay-in ceiling or through a concealed space is to provide a barrier to limit the passage of smoke. The intent of 19.3.6.2.6 is not to require light-tight barriers above lay-in ceilings or to require an absolute seal of the room from the corridor. Small holes, penetrations or gaps around items such as ductwork, conduit, or telecommunication lines should not affect the ability of this barrier to limit the passage of smoke.

A.19.3.6.3.1 Gasketing of doors should not be necessary to achieve resistance to the passage of smoke if the door is relatively tight-fitting.

A.19.3.6.3.5 While it is recognized that closed doors serve to maintain tenable conditions in a corridor and adjacent patient rooms, such doors, which under normal or fire conditions are self-closing, might create a special hazard for the personal safety of a room occupant. These closed doors might present a problem of delay in discovery, confining fire products beyond tenable conditions.

Because it is critical for responding staff members to be able to immediately identify the specific room involved, it is suggested that approved automatic smoke detection that is interconnected with the building fire alarm be considered for rooms having doors equipped with closing devices. Such detection is permitted to be located at any approved point within the room. When activated, the detector is required to provide a warning that indicates the specific room of involvement by activation of a fire alarm annunciator, nurse call system, or any other device acceptable to the authority having jurisdiction.

In existing buildings, use of the following options reasonably ensures that patient room doors will be closed and remain closed during a fire:

(1) Doors should have positive latches and a suitable program that trains staff to close the doors in an emergency should be established.
(2) It is the intent of the *Code* that no new installations of roller latches be permitted; however, repair or replacement of roller latches is not considered a new installation.
(3) Doors protecting openings to patient sleeping or treatment rooms, or spaces having a similar combustible loading might be held closed using a closer exerting a closing force of not less than 22 N (5 lbf) on the door latch stile.

A.19.3.6.3.8 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.

A.19.3.6.3.10 It is not the intent of 19.3.6.3.10 to prohibit the application of push-plates, hardware, or other attachments on corridor doors in health care occupancies.

A.19.3.7.3(2) Where the smoke control system design requires dampers in order that the system functions effectively, it is not the intent of the exception to permit the damper to be omitted.

This provision is not intended to prevent the use of plenum returns where ducting is used to return air from a ceiling plenum through smoke barrier walls. Short stubs or jumper ducts

(3) If, in the opinion of the authority having jurisdiction, special hazards are present, a lock on the enclosure specified in 19.5.2.3(3) and other safety precautions shall be permitted to be required.

19.5.3 Elevators, Escalators, and Conveyors. Elevators, escalators, and conveyors shall comply with the provisions of Section 9.4.

19.5.4 Rubbish Chutes, Incinerators, and Laundry Chutes.

19.5.4.1 Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire-resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with Section 9.5.

19.5.4.2 Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with Section 9.7. *(See Section 9.5.)*

19.5.4.3 Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with Section 8.7.

19.5.4.4 Existing flue-fed incinerators shall be sealed by fire-resistive construction to prevent further use.

19.6 Reserved.

19.7* Operating Features.

19.7.1 Evacuation and Relocation Plan and Fire Drills.

19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary.

19.7.1.2 All employees shall be periodically instructed and kept informed with respect to their duties under the plan required by 19.7.1.1.

19.7.1.3 A copy of the plan required by 19.7.1.1 shall be readily available at all times in the telephone operator's location or at the security center.

19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.

19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

19.7.1.7 When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.

19.7.1.8 Employees of health care occupancies shall be instructed in life safety procedures and devices.

19.7.2 Procedure in Case of Fire.

19.7.2.1* Protection of Patients.

19.7.2.1.1 For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel.

19.7.2.1.2 The basic response required of staff shall include the following:

(1) Removal of all occupants directly involved with the fire emergency
(2) Transmission of an appropriate fire alarm signal to warn other building occupants and summon staff
(3) Confinement of the effects of the fire by closing doors to isolate the fire area
(4) Relocation of patients as detailed in the health care occupancy's fire safety plan

19.7.2.2 Fire Safety Plan. A written health care occupancy fire safety plan shall provide for the following:

(1) Use of alarms
(2) Transmission of alarm to fire department
(3) Emergency phone call to fire department
(4) Response to alarms
(5) Isolation of fire
(6) Evacuation of immediate area
(7) Evacuation of smoke compartment
(8) Preparation of floors and building for evacuation
(9) Extinguishment of fire

19.7.2.3 Staff Response.

19.7.2.3.1 All health care occupancy personnel shall be instructed in the use of and response to fire alarms.

19.7.2.3.2 All health care occupancy personnel shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions:

(1) When the individual who discovers a fire must immediately go to the aid of an endangered person
(2) During a malfunction of the building fire alarm system

19.7.2.3.3 Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box, then shall execute immediately their duties as outlined in the fire safety plan.

19.7.3 Maintenance of Exits.

19.7.3.1 Proper maintenance shall be provided to ensure the dependability of the method of evacuation selected.

19.7.3.2 Health care occupancies that find it necessary to lock exits shall, at all times, maintain an adequate staff qualified to release locks and direct occupants from the immediate danger area to a place of safety in case of fire or other emergency.

19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:

(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
(3) Smoking by patients classified as not responsible shall be prohibited.
(4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision.

(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

19.7.5 Furnishings, Bedding, and Decorations.

19.7.5.1* Draperies, curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1 *(see 19.3.5.6)*, and the following also shall apply:

(1) Such curtains shall include cubicle curtains.
(2) Such curtains shall not include curtains at showers.

19.7.5.2 Newly introduced upholstered furniture within health care occupancies shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2(2) and 10.3.3.

19.7.5.3 The requirement of 19.7.5.2 shall not apply to upholstered furniture belonging to the patient in sleeping rooms of nursing homes where the following criteria are met:

(1) A smoke detector shall be installed in such rooms.
(2) Battery-powered single-station smoke detectors shall be permitted.

19.7.5.4 Newly introduced mattresses within health care occupancies shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2(3) and 10.3.4.

19.7.5.5 The requirement of 19.7.5.4 shall not apply to mattresses belonging to the patient in sleeping rooms of nursing homes where the following criteria are met:

(1) A smoke detector shall be installed in such rooms.
(2) Battery-powered, single-station smoke detectors shall be permitted.

19.7.5.6 Combustible decorations shall be prohibited in any health care occupancy unless one of the following criteria is met:

(1) They are flame-retardant.
(2) They are decorations such as photographs and paintings in such limited quantities that a hazard of fire development or spread is not present.

19.7.5.7 Soiled linen or trash collection receptacles shall not exceed 121 L (32 gal) in capacity, and the following also shall apply:

(1) The average density of container capacity in a room or space shall not exceed 20.4 L/m^2 (0.5 gal/ft^2).
(2) A capacity of 121 L (32 gal) shall not be exceeded within any 6-m^2 (64-ft^2) area.
(3) Mobile soiled linen or trash collection receptacles with capacities greater than 121 L (32 gal) shall be located in a room protected as a hazardous area when not attended.
(4) Container size and density shall not be limited in hazardous areas.

19.7.6 Maintenance and Testing. *(See 4.6.13.)*

19.7.7* Engineered Smoke Control Systems.

19.7.7.1 Existing engineered smoke control systems, unless specifically exempted by the authority having jurisdiction, shall be tested in accordance with established engineering principles.

19.7.7.2 Systems not meeting the performance requirements of such testing shall be continued in operation only with the specific approval of the authority having jurisdiction.

19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met:

(1) Such devices are used only in nonsleeping staff and employee areas.
(2) The heating elements of such devices do not exceed 100°C (212°F).

19.7.9 Construction, Repair, and Improvement Operations.

19.7.9.1 Construction, repair, and improvement operations shall comply with 4.6.11.

19.7.9.2 The means of egress in any area undergoing construction, repair, or improvements shall be inspected daily for compliance with of 7.1.10.1 and shall also comply with NFPA 241, *Standard for Safeguarding Construction, Alteration, and Demolition Operations.*

Chapter 20 New Ambulatory Health Care Occupancies

20.1 General Requirements.

20.1.1 Application.

20.1.1.1 General.

20.1.1.1.1 The requirements of this chapter shall apply to the following:

(1) New buildings or portions thereof used as ambulatory health care occupancies *(see 1.3.1)*
(2) Additions made to, or used as, an ambulatory health care occupancy *(see 4.6.7 and 20.1.1.4)*, unless all of the following criteria are met:
   (a) The addition is classified as an occupancy other than an ambulatory health care occupancy.
   (b) The addition is separated from the ambulatory health care occupancy in accordance with 20.1.2.2.
   (c) The addition conforms to the requirements for the specific occupancy.
(3) Alterations, modernizations, or renovations of existing ambulatory health care occupancies *(see 4.6.8 and 20.1.1.4)*
(4) Existing buildings or portions thereof upon change of occupancy to an ambulatory health care occupancy *(see 4.6.12)*

20.1.1.1.2 Ambulatory health care facilities shall comply with the provisions of Chapter 38 and this chapter, whichever is more stringent.

20.1.1.1.3 This chapter establishes life safety requirements, in addition to those required in Chapter 38, for the design of all ambulatory health care occupancies as defined in 3.3.152.1.

20.1.1.1.4 Buildings, or sections of buildings, that primarily house patients who, in the opinion of the governing body of the facility and the governmental agency having jurisdiction, are capable of exercising judgment and appropriate physical action for self-preservation under emergency conditions shall

Summit Medical Center

TRISTAR HEALTH SYSTEM

March 16, 2007

ATTN: Nina Monroe, Regional Administrator
State of Tennessee
Department of Health
Bureau of Health Licensure and Regulation
Middle Tennessee Regional Office
710 Hart Lane, 1st Floor
Nashville, TN 37247-0530

Dear Ms. Monroe:

Attached you will find our plan of correction to the Statement of Deficiencies resulting from your State Licensure Survey of Summit Medical Center on March 6, 2007.

If there are any questions, please contact me at 615-316-3645.

Sincerely,

Ted Jones
Director of Operations and Facilities

TJ/ds

Cc: Tom Ozburn, COO
Colleen Patterson, Director of Quality Management

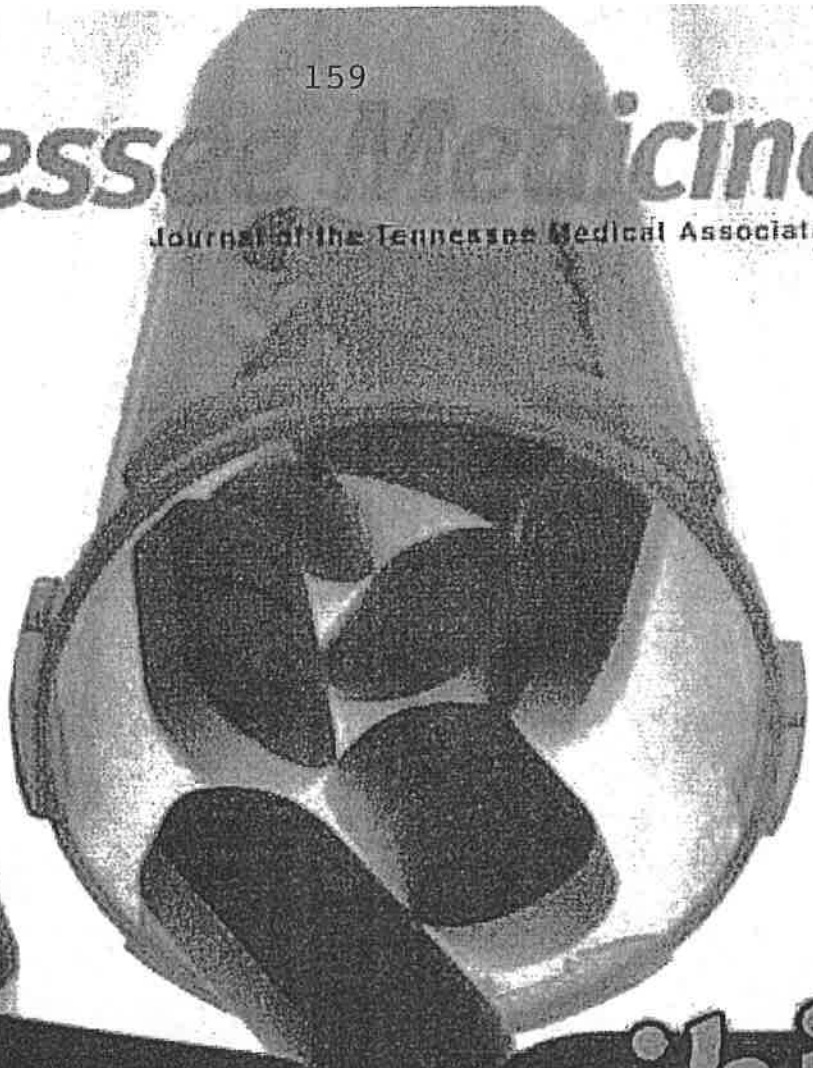
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 03/06/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{H 901}	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Statute is not met as evidenced by: Surveyor: 13846 Based on observation and inspection, it was determined the facility failed to comply with the life safety codes. The findings included: On 3/02/07 at approximately 10:00 AM, inspection of the corridors revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99, 9.6.3.2.1 Inspection of the patient rooms on second, third, fourth, fifth, sixth, and seventh floors revealed the doors are not constructed to resist the passage of smoke. NFPA 101, 19.3.6.2	{H 901}	CONFERRED WITH BILL HARMON ON 3.6.07. WITH NO SMOKING SIGNAGE ON MAIN ENTRANCES FOR GENERAL PUBLIC HE FELT WE HAD MET INTENT OF NFPA 99. CRASH CARTS AND BEDS FOR TRANSPORTING PATIENTS WITH OXYGEN BOTTLES ARE NOT CONSIDERED STORED. UL LISTED SMOKE SEALS ARE BEING INSTALLED ON PATIENT ROOM DOORS.	4.20.07

Miscellaneous Information

Tennessee Medicine
Journal of the Tennessee Medical Association



Overprescribing in Tennessee: Put A Lid On It

Doctors Engaged in the Rx Solution

Examining Antibiotic Use

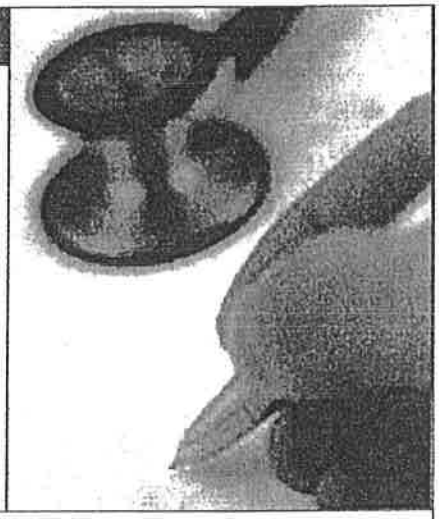
TMA Election Results

Proper Death Certification

VOL. 105, NO. 4 | APRIL 2012

www.tnmed.org

THE JOURNAL
ORIGINAL CONTRIBUTION



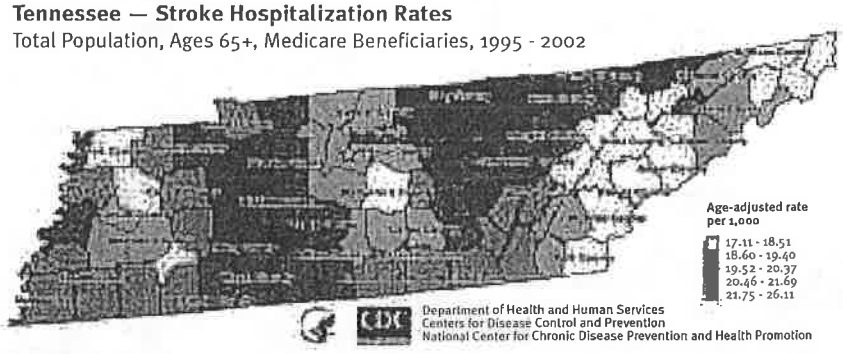
Access to Heart Disease and Stroke Care in Tennessee

By Roberta Hern, MPH; Rachel Swafford; Greg Winters, MPH; and Timothy E. Aldrich, PhD, MPH

ABSTRACT

Tennessee is ranked fourth-worst in the United States for deaths caused by stroke and third-worst in the nation for cardiovascular deaths. Two recent surveys provide information about the geographic distribution of hospital-based, primary and secondary care promotion, and of emergency medical services for these disease conditions. This article is a synthesis of selected findings from these surveys to identify priority populations for interventions to reduce cardiac and stroke mortality in Tennessee. Twenty-three counties have a medical facility with a formal clinical pathway or system for implementing cardiovascular disease prevention strategies. Sixty-three of the state's 95 counties have no designated specialty center for an EMS service to transport cardiac and stroke patients. Fifty-six counties, comprising 38 percent of the state's population, lie between 20 and 50 miles from the nearest state-of-the-art stroke care. Twenty-one counties, containing nearly 10 percent of the state's population, are greater than 50 miles from advanced stroke care facility. Some health districts are faring better than the state proportion (86.8 percent) for people indicating they would call 911 for a suspected cardiac or stroke emergency, while many are performing much poorer. The Shelby district (Memphis) is much higher ($p < 0.01$), while Madison and South Central districts are well below the state's prevalence ($p < 0.001$). The fact that these "less-likely-to-call-911" areas are also in mostly rural settings poses priority challenges for public education. To combat this trend, coordinated efforts are in progress to incentivize the development of cardiac and stroke centers or, alternatively, the formation of regional collaborative networks affiliated with a specialty center.

FIGURE 1. Medicare admissions for stroke: 1995-2002.



INTRODUCTION

The stroke rate in Tennessee is among the highest in the United States. According to recent statistics, Tennessee is ranked fourth-worst in the U.S. for deaths caused by stroke.[1] Data gathered by the Tennessee State Health Department in 2005 indicated Tennessee was ranked third-worst in the nation for cardiovascular deaths.[2] These statistics emphasize our state's need for education concerning techniques for primary and secondary prevention of heart disease and stroke.

In 2006, East Tennessee State University partnered with the Heart Disease and Stroke Prevention program of the Tennessee Department of Health to compile a "Heart Disease and Stroke Prevention Services" survey. These findings became part of the "Heart Disease and Stroke Prevention Inventory" for Tennessee counties. As such the results, along with a series of Healthy Living components (e.g., dietary and exercise behaviors), were published in a monograph entitled *Report of Healthful Living and Services for Cardiovascular Disease in Tennessee*, 2006.

In 2007, the section for Licensure and Education for the Tennessee Division of Emergency Medical Services conducted an assessment of all EMS regions in Tennessee utilizing a CDC-developed survey/assessment tool. The survey was expressly directed to services for cardiac and stroke patients.

Tennessee contains many excellent healthcare facilities. Nonetheless, there are "gaps" and disparities in access to state-of-the art cardiac and stroke care (Figure 1).

FIGURE 2. Areas without access to skilled stroke care.

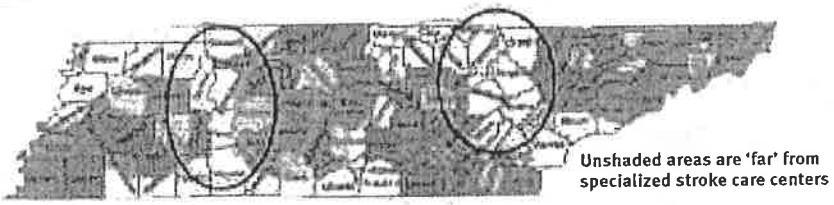


FIGURE 3. Participation in the Heart Disease and Stroke Prevention Services Survey.

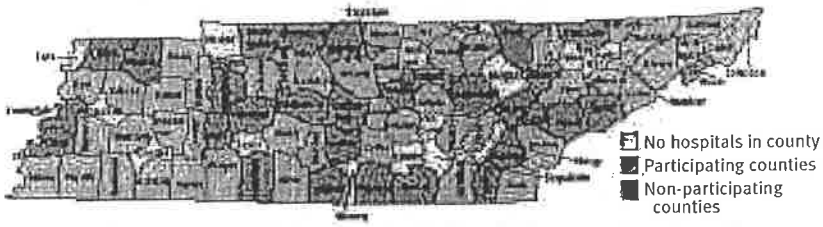


FIGURE 4. County location of "home-base" for EMS Survey respondents.

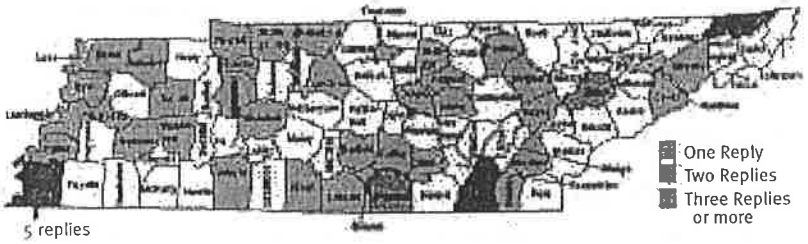


FIGURE 5. Counties having at least one medical facility that reported having a pathway or system to implement cardiovascular disease prevention strategies (light blue).

This figure indicates the densest areas for stroke admissions paid for by Medicare.[3] There are 907,000 Tennesseans who are more than 50 miles from a primary stroke center or 25 miles from a skilled stroke facility (Figure 2). Note that much of the greatest use area is concomitant with those without access to stroke services.[4] Several organizations in the state, under the aegis of a statewide plan, formed working groups to improve the outcomes for cardiac and stroke events in Tennessee.[5]

METHODS

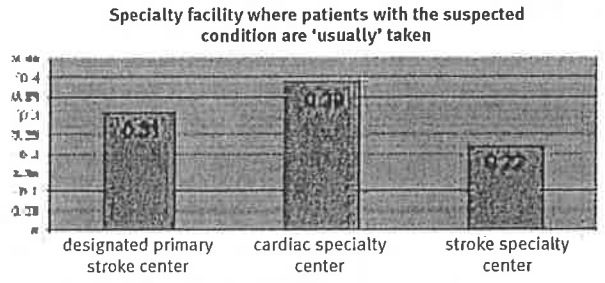
The questionnaire for the Heart Disease and Stroke Prevention Services survey of hospitals was modeled after a Minnesota statewide survey. The questionnaire was initially pilot-tested at Johnson City Medical Center with interviewers trained at the same facility. Data was collected regarding policies and infrastructure that facilitate primary and secondary stroke prevention. From this, the Tennessee Hospital Association (THA) developed a list of qualifying hospital facilities. From May through August 2006, data was collected statewide. Eventually all hospitals found in the membership roster of the THA were contacted.

The primary goal was to collect county-level data. If the county lacked a hospital, the local county health department was contacted to verify the lack of a hospital for the county. Referral information was then collected from these county health departments to determine where patients might go for acute stroke treatment.

Quality control was accomplished by calls to the survey respondents asking them to verify responses to eight selected questions from the instrument. Respondent answers were then compared to the completed survey. Data were analyzed at the county level. Microsoft Excel was used as an analysis tool. Analysis was completed using simple, univariate statistics. Only selected findings from this large report are presented in this manuscript; mainly the findings selected for inclusion were meant to provide a representative perspective of the complete report.[6]

To understand better the heart disease and stroke-related capacities and procedures by local EMS services, the section for Licensure and Education for the Tennessee Division of Emergency Medical Services conducted a statewide survey of EMS providers.[7] The completed EMS surveys were delivered to the Health Disease and Stroke Prevention Program (HDSPP) of the Tennessee Department of Health. They in turn contracted with the ETSU College of Public Health center for data entry, assessment, analysis and interpretation. Duplicate survey responses were found for four EMS services. Simple EXCEL spread sheets were used for analyses. Results were mainly descriptive statistics and minimal statistical testing was conducted. In cases of statistical testing, comparisons were made between groups with the binomial solution for propor-

FIGURE 6. Respondents indicating they had designated stroke centers, cardiac centers or stroke specialty centers identified by protocol for transport of suspected cases.



tions. Significance was interpreted as a p-value of less than 0.05. The findings from the survey data base were prepared in graphic and tabular form, with the specific survey question referenced.[7]

RESULTS

Hospital-Based Cardiovascular Disease and Stroke Prevention Services. Counties that participated in the Heart Disease and Stroke Prevention Services survey for the state of Tennessee (light blue in Figure 3) had at least one medical facility in their county. There were a total of 62 medical facilities that completed the survey, representing 49 counties in the state. Fifteen counties do not have hospitals (Chester, Crockett, Grungy, Grainger, Lake, Lewis, Jackson, Meigs, Moore, Morgan, Pickett, Sequatchie, Stewart, Union and Van Buren); these are shown as yellow in Figure 3.

There were 51 unique responses to the EMS survey. All eight EMS regions are represented; there were at least three replies, per region (Figure 4).

Questions selected from the EMS survey for inclusion with this report dealt with heart disease and stroke prevention services. For example, 23 counties (28 hospitals) each had a medical facility that included a formal clinical pathway or system for implementing cardiovascular disease prevention strategies (Figure 5).

One of the crucial aspects of accessing state-of-the-art cardiac and stroke care is the timely transport of patients experiencing symptoms to medical care.[8] This is most assiduously promoted as "calling 911." Of the 51 responses to the EMS survey, six indicated the EMS served more than a single county (Sullivan, Knox, Davidson, Franklin, Grundy and Shelby) and there were three that crossed state lines (Shelby, Sullivan, Hamilton). Eighty-two percent of the respondents indicated they served a population of less than 100,000 population [39/47 replies]. The majority of the EMS survey respondents were from small services. Seventeen are smaller services (< 4 ground units); only five of the responding EMS services were large, e.g., over 20 vehicles. Five of the respondents did not answer this question. Only two services indicated having a helicopter as part of their services.

One of the primary interests of the EMS survey was to determine services with established protocols for handling suspected cardiac and stroke cases (Figure 6). Most respondents indicated they did not have a designated cardiac or stroke center to deliver patients.

Tennessee has 27 "designated" stroke centers and 42 facilities with a designation of either cardiac center and/or stroke center. The geographic distribution of the respondent EMS services that reported having a designated stroke or cardiac center for transport is aggregated near the state's major metropolitan areas (Figures 7, 8).

Twenty-nine counties served by respondent EMS services had no designated stroke and cardiac centers. Additionally, 34 counties did not provide a response to the survey. By inference, this means 63 of the state's 95 counties may be regarded as not having an EMS service that transports cardiac and stroke patients to a designated specialty center. Based on the county-level analysis of the EMS service coverage and the protocol for transport to a specialized stroke center, an estimate was made of the counties by 20- and 50-mile distances from specialized stroke centers (Figure 9). There are 56 counties (38 percent of the state's population: 2,170,054 people) that are wholly or in large part more than 20 miles but less than 50 miles from state-of-the-art stroke care. There are 21 counties (9.6 percent of the state's population: 544,576 people) that are in part or wholly

FIGURE 7. Counties served by EMS services with either a primary stroke center or a specialty stroke center designated for transport of suspected stroke cases.

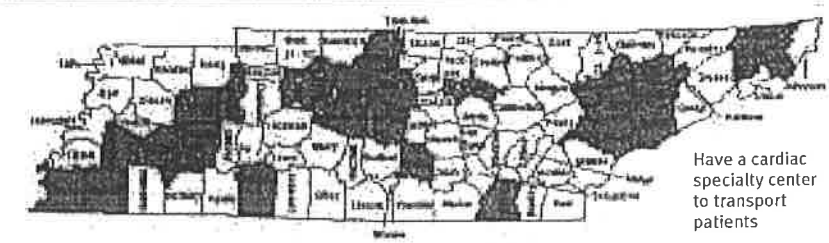


FIGURE 8. Counties served by EMS services with a primary cardiac center designated for transport of suspected cardiac cases.

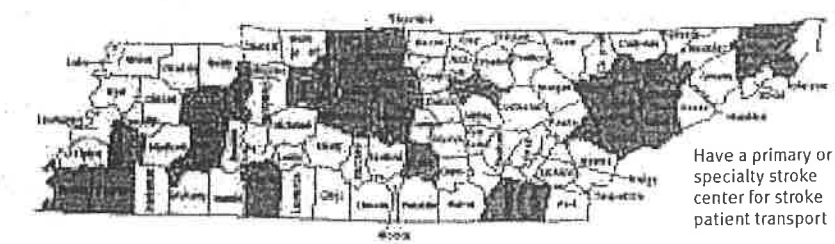
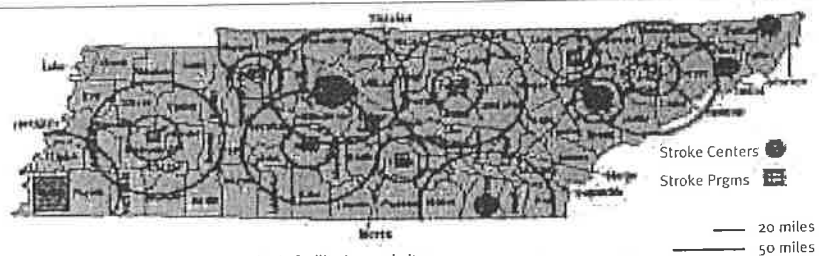


FIGURE 9. Distances to specialized stroke care in Tennessee.*



*Larger figures represent more than a single facility in proximity.

FIGURE 10. 2005 BRFSS data that indicates the proportion of the population in each health district who responded they would call 911 if a heart attack or stroke was suspected.

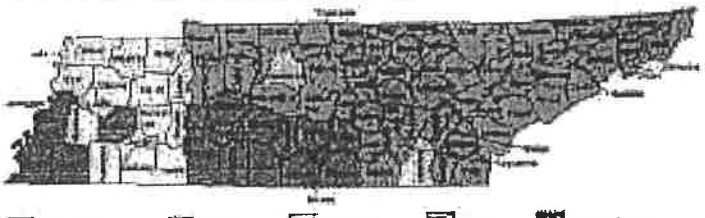
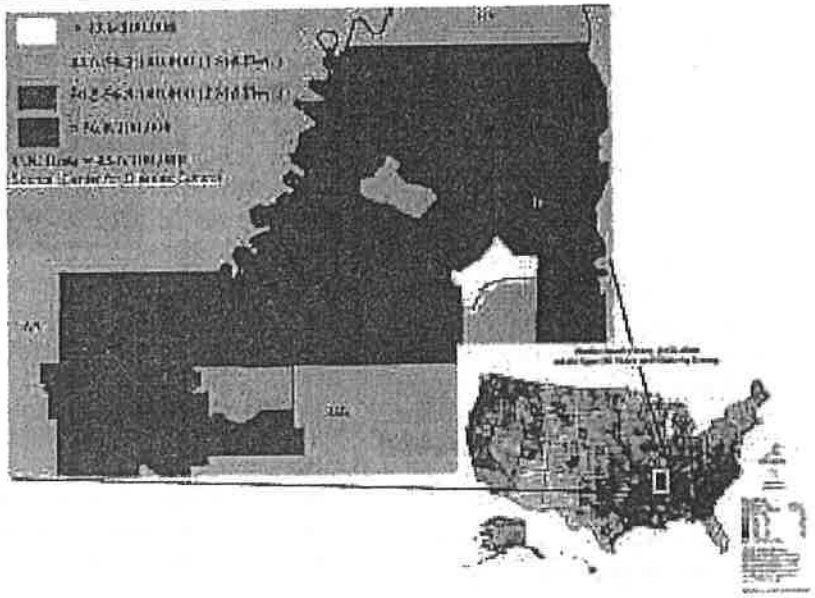


FIGURE 11. Stroke mortality rates for African-American males, 2001-2005.



more than 50 miles from stroke care.

For the purpose of the estimating public awareness to call 911 with a cardiac or stroke emergency, the 2005 Behavioral Risk Factor Surveillance System (BRFSS) was tabulated by Health Districts (Figure 10).[9] Each district had about 320 responses to these random digit dial calls, which should be noted as a design consideration. It was clear that all areas reported high indications for calling 911 in the face of these suspected diagnoses. However, some health districts are statistically significantly higher than the state proportion (86.8 percent, $p < 0.05$), and Shelby is performing even higher ($p < 0.01$).[9]

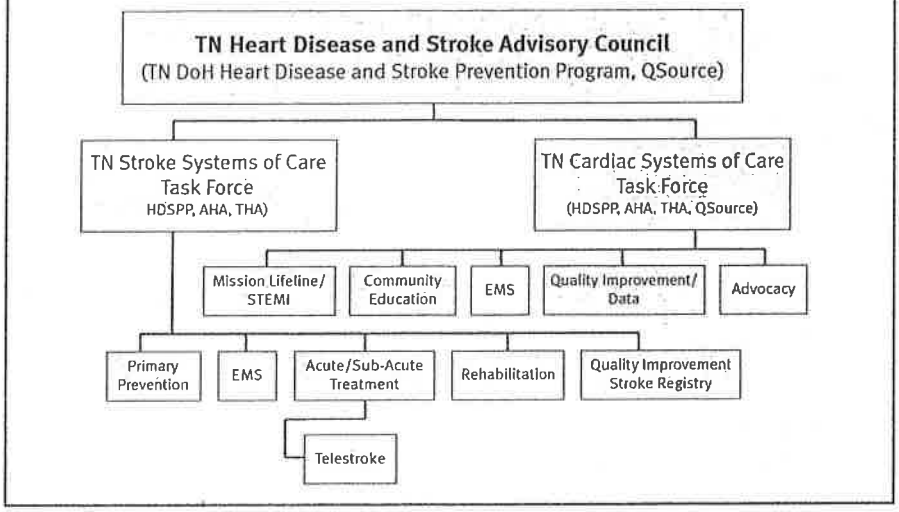
Similarly, but especially important, some regions were doing much worse. The Madison Metropolitan District and South Central District are far lower than the state for respondent prevalence of saying they would call 911 for a suspected cardiac or stroke emergency, $p < 0.001$. The East Tennessee District and the Upper Cumberland District are also lagging behind the rest of the state, $p < 0.05$. Mortality data for stroke shows the region around Madison County has some of the state's highest rates in Tennessee.[10] Also, the observation that most of the "low" and "very low" regions are mostly rural poses a set of priority populations for public education about calling 911 for suspected strokes and heart attacks.

For Tennessee, the metropolitan Shelby County area is also a priority area for intervention. Shelby County has become an epicenter of the "Stroke Belt."[11,12] Besides a dense, urban population, medical facilities and EMS services in this region also serve northwestern Mississippi and northeastern Arkansas. Despite excellent medical services, the African-American population suffers exorbitant stroke mortality rates (Figure 11).

DISCUSSION

The state of Tennessee developed a statewide plan for endeavoring to reduce mortality from heart disease and stroke.[5] Prominent among the goals of that document and the activities of the American Stroke Association's Stroke Systems of Care Committee is the promotion of greater 911 utilization in response to suspected cardiac and stroke events. This emphasis on more rapid and appropriate acute care for these conditions is central to efforts to lower the rates of these preventable deaths. However, many areas of Tennessee are remote to access for these state-of-the-art clinical practices, even if 911 is called. Efforts should be made to incentivize the development of cardiac and stroke centers (associated with national performance criteria and connotes a designated treatment team and an established treatment protocol). Alternatively, there should be promotion of clinical programs versed in the state-of-the-art practice even if those services are not available at their

FIGURE 12. Organizational structure for improving cardiac and stroke outcomes in Tennessee.



specific facility. These care centers are designated as stroke or cardiac "aware" hospitals, and often are affiliated with the respective centers for patient referrals.

Similarly, community educational programs should be distributed to promote patients to request transport to cardiac and stroke centers. These programs should actively promote the importance of calling 911 in a cardiac or stroke emergency, especially in the western part of the state and the south central region. EMS services should be encouraged to align themselves with specialty centers for cardiac and stroke care in their nearby region. Legislation authorizing "bypass" policies for cardiac and stroke emergencies should be sought so that distant-living patients may be transported to specialty care centers. ✚

References:

1. Centers for Disease Control and Prevention: National Center for Health Statistics, CDC WONDER Online Database, compiled from Compressed Mortality File 1999-2006, Series 20(2L), 2009. Available at *http://wonder.cdc.gov/cmf-icd10.html*. Accessed Jun 13, 2010.
2. Tennessee Department of Health: Heart Disease and Stroke Fact Sheet. Available at *http://health.state.tn.us/FactSheets/cardio.htm*.
3. Casper ML, Nwaise IA, Croft JB, Nilasena DS: Atlas of Stroke Hospitalizations Among Medicare Beneficiaries. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Atlanta, 2008. Available at *http://www.cdc.gov/dhdsp/atlas/2008_stroke_atlas/index.htm*.
4. East Tennessee State University College of Public Health: Report of the Tennessee Stroke Registry, 2009. Available at *http://www.etsu.edu/cph/biostat_epidemiology/TNstroke.aspx*.
5. Tennessee Department of Health: Tennessee Heart Disease and Stroke Prevention and Care Plan, Vol. 2, 2008. Available at *http://health.state.tn.us/Downloads/HDS_PreventionBook.pdf*.
6. Hern R, Aldrich TE, Samad Z: Heart Disease and Stroke Prevention Services (an inventory of health care facilities and services). In Report of Services for Cardiovascular Disease and Healthful Living in Tennessee, 2006, Heart Disease and Stroke Prevention Program of the Division of Community Health, and the Division of Training for the EMS Division, Tennessee Department of Health, Nov 2007.
7. Aldrich TE, Savoy, J, Yalamanchali V: Pre-Hospital Heart Attack and Stroke EMS Assessment (2007), Heart Disease and Stroke Prevention Program of the Division of Community Health, and for the Division of Training for the EMS Division, Tennessee Department of Health, 2008.
8. Schwamm LH, Pancioli A, Acker JE, III, Goldstein LB, Zorowitz RD, Shephard TJ, et al: Recommendations for the Establishment of Stroke Systems of Care: Recommendations From the American Stroke Association's Task Force on the Development of Stroke Systems, American Heart Association. Stroke 36:690-703, 2005. Available at *http://stroke.ahajournals.org/cgi/reprint/36/3/690*.
9. Tennessee Department of Health: Tennessee Behavioral Risk Factor Surveillance System, 2005. Available at *http://health.state.tn.us/statistics/brfss.htm*.
10. Tennessee Department of Health: The Burden of Heart Disease and Stroke in Tennessee, 2006 Report* and Special 2007 Update Report. Available at *http://health.state.tn.us/Downloads/Summary.pdf*.
11. Casper ML, Wing S, Anda R, Knowles M, Pollard RA: The shifting Stroke Belt: changes in geographic pattern of stroke mortality in the United States. Stroke 26:755-760, 1995.
12. Howard G, Evans GW, Pearce K, Howard VJ, Bell RA, Mayer EJ, Burke GL: Is the Stroke Belt disappearing? An analysis of racial, temporal, and age effects. Stroke 26:1153-1158, 1995.

Ms. Hern is with the Knox County Health Department; Ms. Swofford is an MPH student in the Department of Public Health at East Tennessee State University; Mr. Winters is with ETSU's Department of Public Health; and Dr. Aldrich is a former associate professor of Epidemiology at ETSU's College of Public Health, now with the UNC Gillings School of Global Public Health in Chapel Hill, NC.

Acknowledgements: We would like to thank and recognize each of ETSU's interviewers: Jennifer Davis, Jonathan Savoy, Brennan McIntyre, B.J. Banjo; Roland Rogers for database development; and Andaleeb Ahmed for assistance with quality control. We thank Karrin Reimheimer of the University of Tennessee and Dr. Cathy Cunningham of Tennessee Technological University for their interviewing efforts. We also appreciate each of the stroke coordinators, hospital administrators and nursing supervisors for their courtesy and assistance in addressing the questionnaire material. We also thank the EMS services who completed that questionnaire. Our thanks to Donna Tidwell of the section for Licensure and Education for the Tennessee Division of Emergency Medical Services.

For reprints and original figures, contact Dr. Aldrich at 919-904-9228 or etsu4ward@gmail.com.

Davidson County, Tennessee

People QuickFacts	Davidson County	Tennessee
Population, 2012 estimate	NA	6,456,243
Population, 2011 estimate	635,475	6,399,787
Population, 2010 (April 1) estimates base	626,681	6,346,113
Population, percent change, April 1, 2010 to July 1, 2012	NA	1.7%
Population, percent change, April 1, 2010 to July 1, 2011	1.4%	0.8%
Population, 2010	626,681	6,346,105
Persons under 5 years, percent, 2011	7.1%	6.3%
Persons under 18 years, percent, 2011	21.8%	23.3%
Persons 65 years and over, percent, 2011	10.5%	13.7%
Female persons, percent, 2011	51.6%	51.3%
White persons, percent, 2011 (a)	66.2%	79.5%
Black persons, percent, 2011 (a)	27.9%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.4%
Asian persons, percent, 2011 (a)	3.2%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	2.1%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	9.9%	4.7%
White persons not Hispanic, percent, 2011	57.5%	75.4%
Living in same house 1 year & over, percent, 2007-2011	79.3%	84.1%
Foreign born persons, percent, 2007-2011	11.7%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	15.4%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	85.3%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	34.4%	23.0%
Veterans, 2007-2011	40,017	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	23.2	24.0
Housing units, 2011	285,020	2,829,025
Homeownership rate, 2007-2011	56.8%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	37.1%	18.1%
Median value of owner-occupied housing units, 2007-2011	$166,300	$137,200
Households, 2007-2011	254,111	2,457,997
Persons per household, 2007-2011	2.35	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$28,526	$24,197
Median household income, 2007-2011	$46,737	$43,989
Persons below poverty level, percent, 2007-2011	17.7%	16.9%

Business QuickFacts	Davidson County	Tennessee
Private nonfarm establishments, 2010	18,124	131,582[1]
Private nonfarm employment, 2010	370,484	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-7.0	-5.3[1]
Nonemployer establishments, 2010	54,350	465,545
Total number of firms, 2007	64,653	545,348
Black-owned firms, percent, 2007	11.1%	8.4%
American Indian- and Alaska Native-owned firms, percent,		

Wilson County, Tennessee

People QuickFacts	Wilson County	Tennessee
Population, 2012 estimate	NA	6,456,243
Population, 2011 estimate	116,617	6,399,787
Population, 2010 (April 1) estimates base	113,993	6,346,113
Population, percent change, April 1, 2010 to July 1, 2012	NA	1.7%
Population, percent change, April 1, 2010 to July 1, 2011	2.3%	0.8%
Population, 2010	113,993	6,346,105
Persons under 5 years, percent, 2011	6.1%	6.3%
Persons under 18 years, percent, 2011	24.6%	23.3%
Persons 65 years and over, percent, 2011	12.6%	13.7%
Female persons, percent, 2011	51.0%	51.3%
White persons, percent, 2011 (a)	90.2%	79.5%
Black persons, percent, 2011 (a)	6.7%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.4%	0.4%
Asian persons, percent, 2011 (a)	1.2%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.5%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	3.4%	4.7%
White persons not Hispanic, percent, 2011	87.2%	75.4%
Living in same house 1 year & over, percent, 2007-2011	86.0%	84.1%
Foreign born persons, percent, 2007-2011	3.5%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	4.3%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	87.8%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	24.7%	23.0%
Veterans, 2007-2011	9,487	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	27.8	24.0
Housing units, 2011	46,168	2,829,025
Homeownership rate, 2007-2011	81.0%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	9.2%	18.1%
Median value of owner-occupied housing units, 2007-2011	$190,900	$137,200
Households, 2007-2011	42,183	2,457,997
Persons per household, 2007-2011	2.63	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$28,110	$24,197
Median household income, 2007-2011 ✓	$61,400	$43,989
Persons below poverty level, percent, 2007-2011 ✓	8.5%	16.9%

Business QuickFacts	Wilson County	Tennessee
Private nonfarm establishments, 2010	2,349	131,582[1]
Private nonfarm employment, 2010	29,161	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	9.7	-5.3[1]
Nonemployer establishments, 2010	9,584	465,545
Total number of firms, 2007	12,204	545,348
Black-owned firms, percent, 2007	3.7%	8.4%
American Indian- and Alaska Native-owned firms, percent,		

Midmonth Report for October 2012

* This report is a count of people taken in the middle of the month for which the report was run.
* This report is run three months after the month of the report in an effort to reduce fluctuations in the results.

MCO	REGION	Total
AMERIGROUP COMMUNITY CARE	Middle Tennessee	200,096
BLUECARE	East Tennessee	217,919
BLUECARE	West Tennessee	179,923
TENNCARE SELECT	All	45,451
UnitedHealthcare Community Plan	East Tennessee	194,890
	Middle Tennessee	200,119
	West Tennessee	175,076
Grand Total		1,213,475

	Female				Female	Male					
COUNTY	0 - 18	19 - 20	21 - 64	65 -->	Total	0 - 18	19 - 20	21 - 64	65 -->	Male Total	Grand Total
ANDERSON	3,737	304	3,308	621	7,971	3,960	205	1,618	278	6,060	14,031
BEDFORD	3,295	237	2,192	250	5,974	3,411	138	973	105	4,627	10,601
BENTON	898	81	760	153	1,892	978	47	456	66	1,547	3,439
BLEDSOE	743	64	617	120	1,545	830	52	368	54	1,304	2,850
BLOUNT	5,200	438	4,409	697	10,743	5,280	282	2,024	300	7,885	18,629
BRADLEY	5,021	441	4,469	650	10,580	5,416	288	2,000	273	7,976	18,557
CAMPBELL	2,718	238	3,088	660	6,703	2,853	212	1,734	394	5,193	11,896
CANNON	706	65	613	133	1,518	799	43	318	58	1,217	2,735
CARROLL	1,686	142	1,608	336	3,772	1,898	105	830	143	2,977	6,749
CARTER	2,930	230	2,609	709	6,477	3,168	157	1,357	264	4,945	11,422
CHEATHAM	1,789	147	1,404	178	3,517	1,870	116	639	77	2,702	6,219
CHESTER	947	84	807	154	1,993	950	56	327	70	1,404	3,397
CLAIBORNE	1,864	161	1,859	539	4,423	1,913	114	1,178	249	3,454	7,876
CLAY	536	29	427	105	1,097	503	36	273	78	889	1,986
COCKE	2,575	223	2,382	464	5,644	2,623	166	1,353	230	4,371	10,015
COFFEE	3,168	260	2,652	385	6,466	3,248	159	1,161	166	4,734	11,200
CROCKETT	979	77	719	216	1,991	968	50	348	81	1,447	3,438
CUMBERLAND	2,885	225	2,330	509	5,949	3,012	179	1,168	235	4,594	10,543
DAVIDSON	36,495	2,572	27,453	3,240	69,761	37,732	1,770	10,255	1,484	51,242	121,002
DECATUR	577	58	538	203	1,377	673	46	305	74	1,099	2,475
DEKALB	1,165	77	994	197	2,433	1,260	64	535	92	1,950	4,383
DICKSON	2,562	161	2,163	323	5,209	2,665	125	904	97	3,791	8,999
DYER	2,560	229	2,295	419	5,503	2,685	151	977	142	3,955	9,458
FAYETTE	1,578	141	1,197	298	3,214	1,735	85	542	118	2,480	5,694
FENTRESS	1,285	108	1,253	381	3,027	1,396	93	800	187	2,476	5,503
FRANKLIN	1,780	167	1,517	275	3,740	1,836	92	705	110	2,743	6,483
GIBSON	2,933	258	2,604	656	6,452	3,087	218	1,117	276	4,698	11,150
GILES	1,432	142	1,255	270	3,099	1,475	85	651	109	2,320	5,419
GRAINGER	1,335	98	1,116	300	2,848	1,333	61	669	155	2,217	5,066
GREENE	3,300	252	3,081	728	7,361	3,380	180	1,661	366	5,587	12,948
GRUNDY	1,083	108	1,081	222	2,493	1,161	92	603	138	1,995	4,488
HAMBLEN	3,953	260	2,764	582	7,559	3,989	154	1,230	229	5,601	13,160
HAMILTON	15,479	1,235	13,689	2,073	32,476	16,275	811	5,365	764	23,215	55,691
HANCOCK	487	52	521	169	1,229	566	42	314	78	1,001	2,230
HARDEMAN	1,667	143	1,548	355	3,713	1,636	102	732	158	2,627	6,340
HARDIN	1,603	154	1,449	392	3,598	1,655	102	775	199	2,731	6,329
HAWKINS	3,105	298	2,845	564	6,811	3,269	164	1,464	262	5,159	11,971
HAYWOOD	1,444	128	1,326	308	3,205	1,521	97	410	113	2,141	5,346
HENDERSON	1,668	138	1,461	270	3,536	1,668	90	665	99	2,523	6,059
HENRY	1,933	155	1,606	290	3,984	1,998	130	749	118	2,996	6,980

HICKMAN	1,437	135	1,278	180	3,030	1,548	112	671	83	2,414	5,444
HOUSTON	440	48	394	118	1,000	487	32	203	74	795	1,795
HUMPHREYS	955	83	823	152	2,013	950	48	389	69	1,456	3,469
JACKSON	635	41	614	153	1,443	663	28	351	94	1,136	2,579
JEFFERSON	2,834	204	2,218	518	5,775	2,903	142	1,099	191	4,336	10,110
JOHNSON	951	79	894	296	2,220	947	70	577	160	1,753	3,974
KNOX	17,492	1,334	15,695	2,433	36,953	18,238	881	6,592	982	26,692	63,645
LAKE	423	42	523	156	1,144	508	33	219	69	829	1,974
LAUDERDALE	1,967	160	1,829	318	4,274	2,055	127	727	125	3,033	7,307
LAWRENCE	2,332	184	1,976	415	4,906	2,519	139	949	171	3,779	8,685
LEWIS	709	55	595	128	1,488	762	43	275	61	1,140	2,628
LINCOLN	1,795	158	1,409	332	3,693	1,895	101	701	123	2,819	6,512
LOUDON	2,129	138	1,531	310	4,108	2,088	94	701	118	3,000	7,108
MACON	1,594	153	1,291	259	3,297	1,715	90	675	108	2,588	5,885
MADISON	6,027	505	5,377	839	12,748	5,977	334	1,770	328	8,408	21,156
MARION	1,675	175	1,580	268	3,698	1,680	102	681	143	2,606	6,303
MARSHALL	1,634	132	1,305	175	3,246	1,690	78	558	68	2,394	5,640
MAURY	4,219	316	3,493	563	8,591	4,566	244	1,328	194	6,333	14,924
MCMINN	2,750	241	2,468	528	5,986	2,980	168	1,153	223	4,524	10,510
MCNAIRY	1,722	176	1,661	414	3,973	1,779	143	914	208	3,043	7,016
MEIGS	739	67	628	86	1,521	710	55	320	49	1,134	2,655
MONROE	2,532	224	2,226	517	5,500	2,811	153	1,184	249	4,396	9,897
MONTGOMERY	6,937	567	5,760	662	13,925	7,172	312	1,818	221	9,524	23,449
MOORE	233	22	157	48	461	270	9	99	15	393	853
MORGAN	1,126	93	902	192	2,313	1,184	79	523	103	1,888	4,201
OBION	1,768	152	1,563	307	3,790	1,886	86	583	106	2,660	6,450
OVERTON	1,128	86	943	279	2,436	1,244	64	541	146	1,995	4,431
PERRY	524	40	393	87	1,044	527	32	213	41	814	1,857
PICKETT	222	22	187	97	528	270	7	128	50	455	983
POLK	910	57	829	157	1,952	950	57	460	84	1,550	3,502
PUTNAM	3,729	359	3,247	776	8,111	3,926	230	1,712	323	6,191	14,301
RHEA	2,254	178	1,811	350	4,592	2,285	119	871	139	3,415	8,007
ROANE	2,368	208	2,359	562	5,496	2,713	140	1,308	235	4,396	9,892
ROBERTSON	3,551	237	2,361	384	6,534	3,686	124	980	160	4,949	11,483
RUTHERFORD	11,385	949	8,014	990	21,337	11,841	576	2,921	370	15,709	37,046
SCOTT	1,838	158	1,691	409	4,095	1,862	124	973	195	3,154	7,249
SEQUATCHIE	900	78	758	145	1,881	955	50	434	62	1,502	3,382
SEVIER	4,778	318	3,139	466	8,701	5,110	204	1,245	171	6,730	15,431
SHELBY	69,327	6,343	56,115	6,652	138,436	71,012	4,414	15,989	2,428	93,843	232,280
SMITH	1,014	84	883	185	2,165	1,034	61	410	65	1,569	3,734
STEWART	701	50	646	122	1,519	710	26	309	58	1,102	2,621
SULLIVAN	7,087	623	6,740	1,359	15,810	7,364	409	3,389	616	11,778	27,587
SUMNER	6,696	567	5,368	819	13,449	7,156	378	2,061	303	9,898	23,347
TIPTON	3,463	343	2,595	371	6,771	3,620	211	918	149	4,898	11,669
TROUSDALE	451	40	361	84	936	458	35	184	37	715	1,651
UNICOI	914	72	813	283	2,081	1,002	54	377	130	1,563	3,644
UNION	1,301	113	921	166	2,501	1,313	73	527	89	2,002	4,503
VAN BUREN	299	28	257	61	644	331	13	155	47	546	1,190
WARREN	2,509	183	2,151	449	5,292	2,651	130	1,066	185	4,032	9,324
WASHINGTON	4,874	453	4,848	994	11,167	5,059	296	2,241	387	7,983	19,151
WAYNE	779	65	647	178	1,670	831	29	347	83	1,289	2,959
WEAKLEY	1,700	204	1,513	310	3,726	1,741	125	720	116	2,702	6,428
WHITE	1,516	130	1,295	342	3,272	1,622	93	762	120	2,597	5,869
WILLIAMSON	2,647	166	1,763	353	4,929	2,837	137	714	113	3,801	8,730
WILSON	4,107	311	3,288	508	8,215	4,301	198	1,389	192	6,080	14,294
Grand Total	341,125	28,330	284,125	47,689	701,270	355,071	19,267	117,953	19,914	512,205	1,213,474

SUPPORT LETTERS

2013 APR 11 AM 8 54

Signature HealthCARE

Care Redefined

2/06/2013

Jeff Whitehorn CEO
Summit Medical Center
5655 Frist BLVD
Hermitage TN 37076

Dear Mr. Whitehorn:

Signature Healthcare LLC and Donelson Care and Rehab Center would like to offer our support for your proposed 12 bed acute inpatient rehabilitation center located at Summit Medical Center in Hermitage. Signature strives to enhance the continuum of care for the local community, and we appreciate your efforts to do so with this proposed project.

We look forward to partnering with you to ensure that your patients receive the best care post discharge while minimizing unnecessary re-hospitalizations. Please let us know how we can best be a partner as you continue to improve the healthcare care continuum for the community.

Sincerely,

Mick Vujanovic MA NHA CNA
Regional Vice President
SIGNATURE HEALTHCARE, LLC
12201 Bluegrass Parkway
Louisville, KY 40299
Ph: 502.548.8828 Fx: 502.568.7152
mvujanovic@shccs.com

NHC
NATIONAL HEALTHCARE CORPORATION

March 8, 2013

Ms. Melanie Hill, Executive Director
State of Tennessee
Health Services & Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: TriStar Summitt Medical Center CON for the addition of Acute Care Rehab Beds

Dear Ms. Hill:

National HealthCare Corporation is the largest provider of skilled nursing care in the Middle Tennessee service area. We have 1,058 beds in 8 facilities in the Nashville-Murfreesboro-Franklin MSA, and we are a major provider of rehabilitation services. For example, NHC's 5,000 square-foot therapy gym at our Cool Springs facility in Williamson County currently has 35-40 therapists working daily with rehab patients.

As a major senior care provider, NHC knows how important it is for rehab services to be coordinated – from the trauma centers through acute care hospitals, rehab hospitals, skilled nursing facilities, home health agencies, and outpatient therapy services.

You may recall that in past years we have opposed additional rehab beds in this area. That was primarily because we did not believe coordination would be established and maintained with existing providers already operating within the community, and consequently, that services would merely be duplicated and provided in a more costly setting.

The TriStar project seems to have taken a different approach. NHC and TriStar officials have had numerous discussions regarding how we might better coordinate the distinctive services that each entity offers toward a goal of greater efficiency and improved quality of care for the patients we serve. Instead of a model where providers work totally independently of each other, we believe that TriStar is making a serious effort to establish a coordinated care model which would benefit the patients involved. For example, NHC will coordinate with TriStar and other physicians at this Rehab Unit to improve care for our patients and to also make sure that patients are treated in the appropriate setting and with appropriate protocols.

NHC leadership believes that coordination between providers is exactly where healthcare is going for improved patient care regardless of the healthcare setting.

Furthermore, we are enthusiastic about this approach, and we believe patients in the service area will truly benefit from this coordinated care model being developed.

Sincerely,

NATIONAL HEALTHCARE CORPORATION

Bruce K. Duncan
Assistant Vice President

McKendree Village

5 February 2013

Mr. Jeff Whitehorn, CEO
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076.

Dear Jeff,

I am writing in support of Summit Medical Center's Certificate of Need (C.O.N.) application to add a twelve (12) bed inpatient rehabilitation unit. As you know, many of McKendree Village's residents receive care at Summit Medical Center and speak highly of the care and services they have received. In addition, I have personally met with your leadership and know they are committed to providing high quality care.

So, I very much support the approval of your request to the State of Tennessee Health Services and Development Agency to add 12 inpatient rehabilitation beds. The McKendree Village team believes this will allow more patients to benefit from the outstanding care and services provided at Summit.

Best Regards,

Molly C. Morand
Vice President

Continued from last column

prior liens and encumbrances of record:
Described property located in the 10th Civil District of Sumner County, Tennessee, to wit:
Being Lot 16 on the Final Subdivision plat of Thoroughbred Crossing, a plat of which is of record in Plat Book 23, Page 25, Register's Office of Sumner County, Tennessee, to which reference is hereby made for a more complete description of said lots.
Street Address: 1005 Steed Court, Gallatin, Tennessee 37066
Parcel Number: 90B-A-5.00
Current Owner(s) of Property: James S. Milam and Melissa Milam, husband and wife
The street address of the above described property is believed to be 1005 Steed Court, Gallatin, Tennessee 37066, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.
SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.
If applicable, the notice requirements of T.C.A. 35-5-117 have been met.
All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.
If the highest bidder cannot pay the bid within twenty-four (24) hours of the sale, the next highest bidder, at their highest bid, will be deemed the successful bidder.
This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time.
Shapiro & Kirsch, LLP Substitute Trustee

Continued to next column

Continued from last column

www.kirschattorneys.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 12-044721

0101640155
SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on May 21, 2013 at 12:00 PM local time, at the east door, Sumner County Courthouse, Gallatin, Tennessee, conducted by Shapiro & Kirsch, LLP Substitute Trustee, pursuant to Deed of Trust executed by Jeffery C. Green, married, husband and Donna L. Green, married, wife, to Grady W. Agee, Trustee, on July 14, 2003 at Record Book 1798, Page 238; all of record in the Sumner County Register's Office.
Holder: JPMorgan Chase Bank, National Association
The following real estate located in Sumner County, Tennessee, will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record:
A certain tract of parcel of land in Sumner County, State of Tennessee, described as follows, to-wit:
Being Lot Number 152 on the plan of Northwoods, Phase 7, Section 2, a plat of record in Plat Book 16, Page 249, Register's Office for Sumner County, Tennessee, for which plan reference is hereby made for a more complete description.
Street Address: 107 Pembroke Court, White House, Tennessee 37188
Parcel Number: 096H-A-025.00
Current Owner(s) of Property: Jeffery C. Green, a married person
Other interested parties: Department of Labor and Workforce Development and GE Money Bank assignee of HH Gregg C/O Wanda W. Cross, Attorney

Continued to next column

Continued from last column

The street address of the above described property is believed to be 107 Pembroke Court, White House, Tennessee 37188. But such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.
SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.
If applicable, the notice requirements of T.C.A. 35-5-117 have been met.
Notice of this Substitute Trustee's Sale has been timely given to the State of Tennessee as required by T.C.A. § 67-1-1433(b)(1).
Terms of Sale will be public auction, for cash, free and clear of rights of homestead, redemption and dower, and the rights of Jeffery C. Green, married, husband and Donna L. Green, married, wife, and those claiming through them, and subject to the right of redemption by the DEPARMENT OF LABOR AND WORK FORCE DEVELOPMENT, STATE OF TENNESSEE by reason of tax lien of record in Record Book 3070 Page 641 at the Register's Office of Sumner County, Tennessee, subject to any accrued taxes and restrictions.
All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.
If the highest bidder cannot pay the bid within twenty-four (24) hours of the sale, the next highest bidder, at their highest bid, will be deemed the successful bidder.
This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time.

Continued to next column

Continued from last colum

Shapiro & Kir
LLP Substi
Trustee
www.kirschatto
s.com
Law Office of
piro & Kirsch, LL
555 Perkins Roa
tended, Sec
Floor
Memphis, TN 381
Phone (901)767-5
Fax (901)761-569
File No. 13-047282

0101638722
SUBSTITUTE TRUSTEE'S SAL

Sale at public
tion will be on
7, 2013 at 10:0
local time, at
east door, Sun
County Courtho
Gallatin, Tennes
conducted by
piro & Kirsch,
Substitute Trus
pursuant to Dee
Trust executed
Charlene Click,
Angie Tuck, Trus
on April 29, 200
Record Book
Page 623, Ins
ment No. 880232
of record in
Sumner County
ister's Office.
Owner of Debt:
Financial Serv
Inc.
The following
estate located
Sumner Cou
Tennessee, will
sold to the hig
call bidder sub
to all unpaid ta
prior liens and
cumbrances of
cord:
All that cer
parcel/unit of
in Sumner Cou
State of TN, as
fully described
Book 2014 Page
ID number 67-1
being known
designated as
number 5A, on
plan of the Miz
Farm, recorded
03/08/2002. File
Plat Book 20,
Page 136.
LOCATED UPON
ABOVE-DESCRI
PROPERTY is a
Southern Lifst
manufactured ho
Serial Num
DSLAL43897AB.
Street Address:
Wolf Hill R
Bethpage, Ten
see 37022
Parcel Number:
16.08
Current Owner(s
Property: Char
Click, unmarried
The street add
of the above de
bed property is
lieved to be 609
Hill Road, Bethp

Continued to next c

0101642102
NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to convert eight (8) inpatient psychiatric beds to medical-surgical beds, and to convert twelve (12) inpatient psychiatric beds into a new twelve (12) bed acute inpatient rehabilitation unit and service at its campus, at 5655 Frist Boulevard, Hermitage, TN 37076. Inpatient psychiatric services will no longer be provided at Summit Medical Center. The estimated capital cost is $5,000,000.
TriStar Summit Medical Center is a general hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 188 hospital beds. The project will not change its licensed hospital bed complement. It will not initiate or discontinue any health service other than described above, or add any major medical equipment. Upon opening of the Summit rehabilitation unit, TriStar Skyline Medical Center will delicense ten (10) acute inpatient rehabilitation beds at its satellite campus at 500 Hospital Drive, Madison, TN 37115.
The anticipated date of filing the application is on or before April 15, 2013. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215; (615) 665-2022.
Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Antiques

Fly Cultural Art Center SHELBYVILLE
11th Annual Regional Postcard & Paper Memoriabilia Show
Sat. 4/13, 9am - 4pm
204 South Main Street
Call: 931-684-1068 or 931-580-6134

HOOSIER CABINET, white

Furniture

BARGAINS GALORE
OFFICE FURNITURE & Cubicles, Pre-owned
www.bfwnashville.com
615-775-1193

Good Things To Eat

Garage Sales - Area 2 - Davidson Co.

MONTGOMERY BELL ACADEMY AUX GYM LADIES DESIGNER CONSIGNMENT SALE
Fri, April 12, 12 pm -6 pm
Sat, April 13, 8 am-12 pm
4001 HARDING RD.
Wide variety of sizes. All Seasons. Dolce & Gabbana, Gucci, Prada and many more!

Cats

BENGAL KITTENS, Domestic w/wild age. 1st shots. $40 Male, 1yr old, good te er, $500. 256-423-691

Dogs

IMPORTANT NOTI Use caution when as in

75 ad,

Real Estate Commercial

Commercial Property For Lease

7500-16,000 SQ.FT. Commerical Industrial Warehouse Office Space. 3 phase electricity. 4 acres of land. 1980

Motorcycles

IMPORTANT NOTE: Use caution when asked to wire money for a vehicle. In some cases money has been transferred and no vehicle was delivered.

SLOAN'S SUPERCENTER BUYS USED BIKES, ATVs, Or DOES CONSIGNMENTS. Japanese & Harleys. Jim 615-714-9526

COPY-

SUPPLEMENTAL-1

Summit Medical Ctr.-Rehab

CN1304-011

SUPPLEMENTAL

DSG Development Support Group

2013 APR 19 PM 3:42

April 19, 2013

Phillip M. Earhart, Health Planner III
Tennessee Health Services and Development Agency
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37203

RE: CON Application #CN1304-011
Summit Medical Center--Rehabilitation Service & Bed Conversion

Dear Mr. Earhart:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit. Please note that some responses will be forwarded under separate cover.

1. **Section A, Applicant Profile, Item 2**
   Please provide a full contact phone number and submit a replacement page.

   Revised page 1R is attached following this page.

2. **Section A, Applicant Profile, Item 8**
   The applicant is proposing to convert eight (8) inpatient psychiatric beds to medical surgical beds, and twelve (12) inpatient psychiatric beds into a new twelve (12) bed acute inpatient rehabilitation unit. Please check box G. Change in bed complement and resubmit a replacement page.

   Revised page 2R is attached following this page.

3. **Section B, Project Description, Item I.**
   a. The applicant states 82% of Summit's admissions historically have come from Davidson and Wilson counties. Please verify the data source for this information. Please re-verify.

   The 2011 Joint Annual Report for Summit Medical Center indicates that 84% of its admissions came from Davidson and Wilson Counties. That percentage in the 2010 Joint Annual Report was also 84%. Attached is revised page 31R.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

SUPPLEMENTAL

b. On the top of page 6 the applicant states the total rehabilitation days provided in the downtown area decreased 15%, while the rehabilitation days provided in the Davidson County suburbs increased 56%. Please confirm the data source and statistics to back this statement.

That statement uses data from Table Six on page 14 of the application. Table Six data were derived from Table 13-B on page 37, which relied on Joint Annual Report data. Attached following this page are the specific calculations for the trends shown in Table Six, and a revised page 14R with a correction to the Table Six footnotes (no change in the data).

c. On page 6 the applicant states there are two non-operational programs with forty-one (41) licensed, but unusable and unstaffed, rehabilitation beds. Please provide the data source and the two facilities the applicant is referring to.

There are 10 non-operational rehabilitation beds at the TriStar Skyline Medical Center satellite campus in Madison. The applicant knows this because Summit and Skyline are sister hospitals owned by the same system (HCA TriStar). The bed status is verified in Skyline Medical Center Madison's JAR's, which show no rehabilitation admissions in recent years.

There are 31 non-operational rehabilitation beds at Nashville Rehabilitation Hospital (NRH). At NRH's request, on January 21, 2010, the Board for Licensing Healthcare Facilities gave NRH's 31-bed license "inactive status" for a two-year period. Inactive status was extended for one year on Feb. 7, 2013. See attached documents following this page. The TDOH website indicates that NRH has not filed a Joint Annual Report after 2008. The facility's phone number has been disconnected.

SUPPLEMENTAL

Nashville Rehabilitation Hospital of Nashville
Rule Making Hearing
Board for Licensing Health Care Facilities
January 21, 2010 Meeting

Attendees:

Turned over to Erin Begley, Staff Attorney

No Chairman or Chairman pro-tem present
Elect Chairman for this meeting - ?????????
Quorum established

New member Dr. John Marshall replacing Carlyle Walton
Dr. Larry Arnold
Dr. Thomas Carr
Elizabeth Chadwell
Alex Gaddy
Paula Collier
Mike Hahn
Sara Snodgrass
Janice Hill
James Weatherington
Dr. Jennifer Gordon Maloney
Dr. Norman Jones
Carissa Lynch
Robert Gordon
Luke Gregory
Annette Marlor
Dixie Taylor Huff
Dr. John Winter

Agency Reps:

Elizabeth Chadwell
Anne Rutherford Reed
???
????
???

Nashville Rehabilitation Hospital, Nashville

Representative(s): Colbey Reagan, Operations Counsel for Psychiatric Solutions

Male: Representative not here, will be here at 1:00. You can approve of disapprove now or we can do it later.

Female: I will go ahead and read what the request is.

Request: This 31 bed hospital is requesting to place their license on inactive licensure status effective December 4, 2009. The last patient was discharged and the hospital operations have ceased effective December 2, 2009.

Female: Would the approval of this not be consistent with what we have done today? I move that we approve this request.

Male: Motion has been made to approve the request, it has been seconded, any discussion?

Male: Just a question, "Is there a period of time that ……..

Female: I would refer to the letter that would be contained within the packet, I would say that since it is not on here they probably didn't specify an amount of time, because we generally capture that if it was there.

Male: I have no problem with it ……????

Female: Two years.

Another Female: Whatever the Board desires.

Male: OK.

Male: Do you still second that motion? OK. All in favor, I….any oppose…..thank you. Looks like we have reached the finale.

Subject: RE: Nashville Rehab
Date: Wednesday, April 17, 2013 3:47 PM
From: Ann R. Reed <Ann.R.Reed@tn.gov>
To: John Wellborn <jwdsg@comcast.net>

The license has not expired. The facility requested another extension of the inactive status at the Feb. 7th, 2013 meeting. These minutes are not available as of today. The request was granted for an additional one year.

Ann Rutherford Reed

Ann Rutherford Reed, RN, BSN, MBA
Director of Licensure
Division of Health Licensure and Regulation
Office of Health Care Facilities
227 French Landing, Suite 501
Heritage Place MetroCenter
Nashville, TN. 37243
Telephone (615)741-7221
Fax (615)253-8798
ann.r.reed@tn.gov <mailto:ann.r.reed@tn.gov>

Connect with TDH on Facebook and Twitter@TNDeptofHealth!

"The mission of the Tennessee Department of Health is to protect, promote, and improve the health and prosperity of people in Tennessee."

Please consider the environment and print this email only if necessary, if you do print, please recycle.

From: John Wellborn [mailto:jwdsg@comcast.net]

SUPPLEMENTAL

d. Please provide a brief overview of the psychiatric services that are currently available at Summit Medical Center. In your response, please indicate the following: population and ages served, the number of private and semi-private rooms, outpatient programs and collaboration with managed care organizations and the Tennessee Department of Mental Health of the possible inpatient 20 bed psychiatric closure.

Summit's psychiatric unit serves only the adult population (ages 18+). It is on a dedicated floor with 20 private patient rooms. It does not provide an outpatient program. In CY2012, Summit discharged a total of 647 patients from that unit, and provided 4,294 patient days of care with an average daily census of 11.8.

The applicant has contacted the Department of Mental Health about the possible need for future collaboration concerning the consolidation of inpatient psychiatric services into the larger adult program at Skyline Medical Center Madison. However, before a CON is granted to convert the underutilized Summit psychiatric floor to other types of services, it is premature to initiate further activity with that Department.

If this CON application is approved, appropriate collaboration will be initiated by Summit to assure that timely and adequate notice is provided to the public and to stakeholders, including area Emergency Medical Services personnel and agencies that have been Summit's referral sources for this service. Also, at the appropriate time, contracted managed care plans (including TennCare MCOs) will be advised of the termination of the inpatient psychiatric service at Summit and its consolidation at Skyline Medical Center Madison.

SUPPLEMENTAL

4. **Section B, Project Description, Item II.**
   a. On page 11 the applicant states "historic and projected utilization and occupancies for all categories of beds are projected in Attachment Four, Section C (II) 4 of the application". The referenced attachment could not be found in the application. Please clarify.

   The quoted reference contains an error. The utilization data are in Table Sixteen, Section C(I)6, p. 42 of the application. Revised page 11R is attached following this page, to correct the reference.

5. **Section B, Project Description, Item II.C.**
   a. The applicant states Summit is one of eighteen (18) Joint Commissioned designated Primary Stroke Centers in the state. Please indicate if there are other Joint Commissioned designated Primary Stroke Centers in the proposed service area.

   A list of the Joint Commission Accredited Primary Stroke Centers in Tennessee is attached following this page. The page provides a link to the Commission website where this information is posted.

   b. What percentage of admissions to the proposed rehab unit will be classified as stroke victims?

   Table 19 on page 58 of the application shows that in Years One and Two, stroke admissions will be 70 and 74 persons respectively, which is 25.9% and 26.0% respectively.

   c. On page 15 of the application under heading "Need to Reassign Beds to an Orthopedic Unit", the applicant states "on 23% of those days, the surgical beds had higher than 90% occupancy, calculated by the standard method using midnight census. Please clarify and define the "standard method using midnight census."

   The midnight census is a head count of patients in the hospital, taken at midnight each night. It is the standard method used by HCA to monitor census activity on a daily basis. It identifies the number of beds occupied at midnight by inpatients, observation patients, and Emergency Department patients awaiting admission.

Certification Program	Organization Name	City	State	Certification Decision	Effective Date
Comprehensive Stroke Center	Fort Sanders Medical Center	Knoxville	TN	Certification	2/8/2013
Comprehensive Stroke Center	Skyline Medical Center	Nashville	TN	Certification	2/1/2013
Primary Stroke Center	Centennial Medical Center	Nashville	TN	Certification	11/3/2012
Primary Stroke Center	Southern Hills Medical Center	Nashville	TN	Certification	6/25/2010
Primary Stroke Center	Saint Thomas Hospital	Nashville	TN	Certification	4/14/2011
Primary Stroke Center	Vanderbilt University Hospital	Nashville	TN	Certification	3/14/2012
Primary Stroke Center	NorthCrest Medical Center	Springfield	TN	Certification	11/10/2012
Primary Stroke Center	UT Medical Center	Knoxville	TN	Certification	11/5/2010
Primary Stroke Center	Blount Memorial Hospital, Inc.	Maryville	TN	Certification	7/24/2012
Primary Stroke Center	Methodist Healthcare Hospitals	Memphis	TN	Certification	10/8/2011
Primary Stroke Center	Middle Tennessee Medical Center	Murfreesboro	TN	Certification	11/19/2011
Primary Stroke Center	Baptist Hospital	Nashville	TN	Certification	6/2/2012
Primary Stroke Center	Wellmont Bristol Medical Center	Bristol	TN	Certification	2/14/2012
Primary Stroke Center	Summit Medical Center	Hermitage	TN	Certification	11/29/2011
Primary Stroke Center	Erlanger Health System	Chattanooga	TN	Certification	3/10/2012
Primary Stroke Center	Horizon Medical Center	Dickson	TN	Certification	1/22/2013
Primary Stroke Center	Johnson City Medical Center	Johnson City	TN	Certification	4/22/2011
Primary Stroke Center	StoneCrest Medical Center	Smyrna	TN	Certification	5/7/2010
Primary Stroke Center	Hendersonville Hospital Corporation	Hendersonville	TN	Certification	1/30/2013
Primary Stroke Center	AMISUB (SFH), Inc	Memphis	TN	Certification	12/4/2012
Stroke Rehabilitation	HealthSouth Rehabilitation Hospital	Kingsport	TN	Certification	2/15/2013
Stroke Rehabilitation	HealthSouth Rehabilitation Hospital	Memphis	TN	Certification	12/13/2012
Stroke Rehabilitation	Rebound, LLC	Martin	TN	Certification	9/26/2012
Stroke Rehabilitation	HealthSouth Chattanooga Rehab	Chattanooga	TN	Certification	2/14/2013
Stroke Rehabilitation	HealthSouth Rehabilitation Hospital	Memphis	TN	Certification	1/28/2012
Stroke Rehabilitation	Vanderbilt Stallworth Rehabilitation	Nashville	TN	Certification	11/2/2011

Source: http://www.qualitycheck.org/StrokeCertificationList.aspx

SUPPLEMENTAL

d. Please provide a line chart that displays the daily occupancy percentage or census over the past year with a line signifying 80%.

Two charts are attached following this page. They show the occupancy of Summit's (a) medical-surgical beds and (b) surgical beds by themselves.

6. Need, Item 1. (Service Specific Criteria-Comprehensive Inpatient Rehabilitation Services, #2)

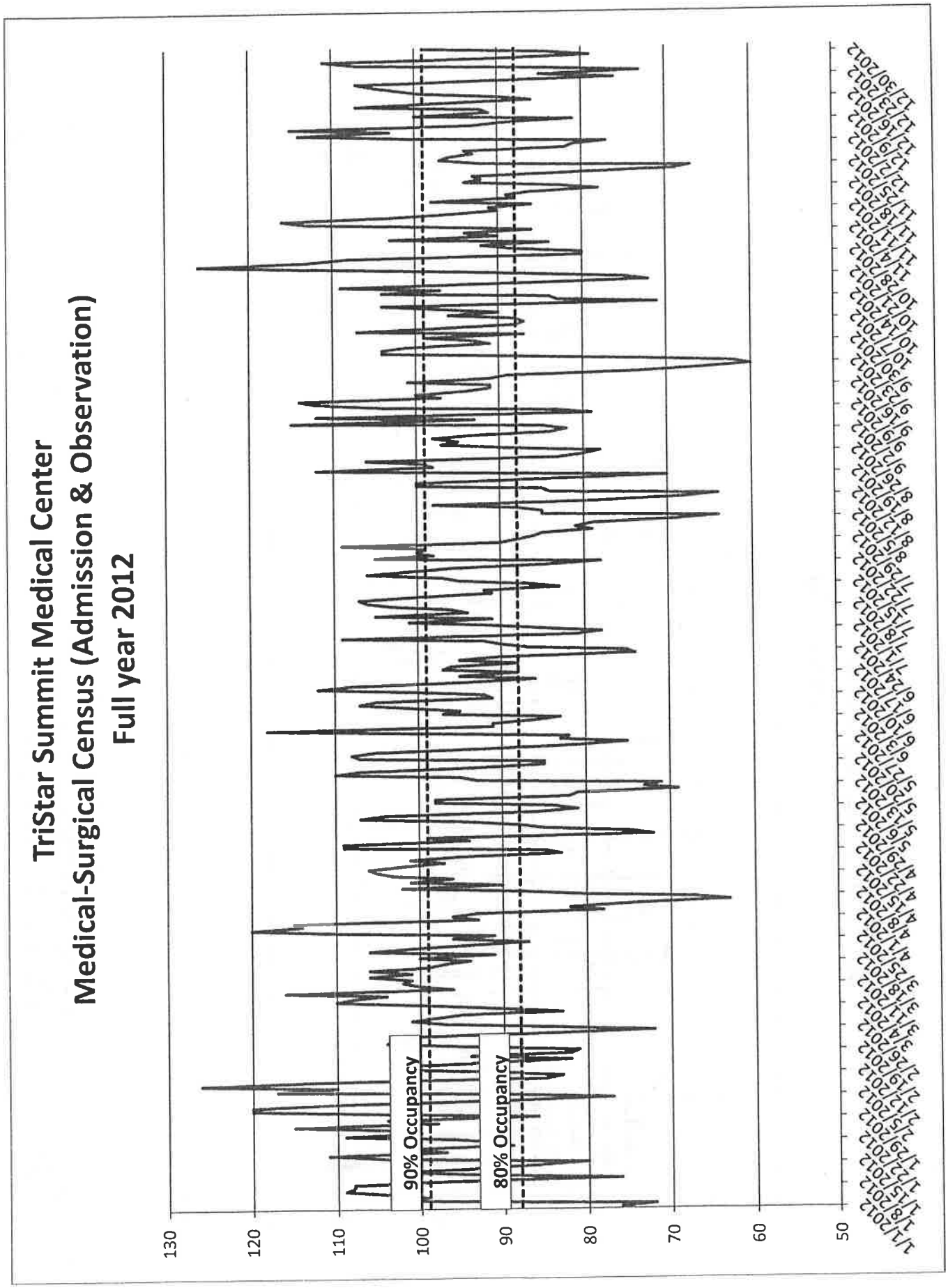
The applicant appears to have made an error in calculating an 80% occupancy in the following formula: 44,086 actual rehabilitation days/365/80%=151. It appears the actual days should have been multiplied by 80% instead of dividing. Please clarify.

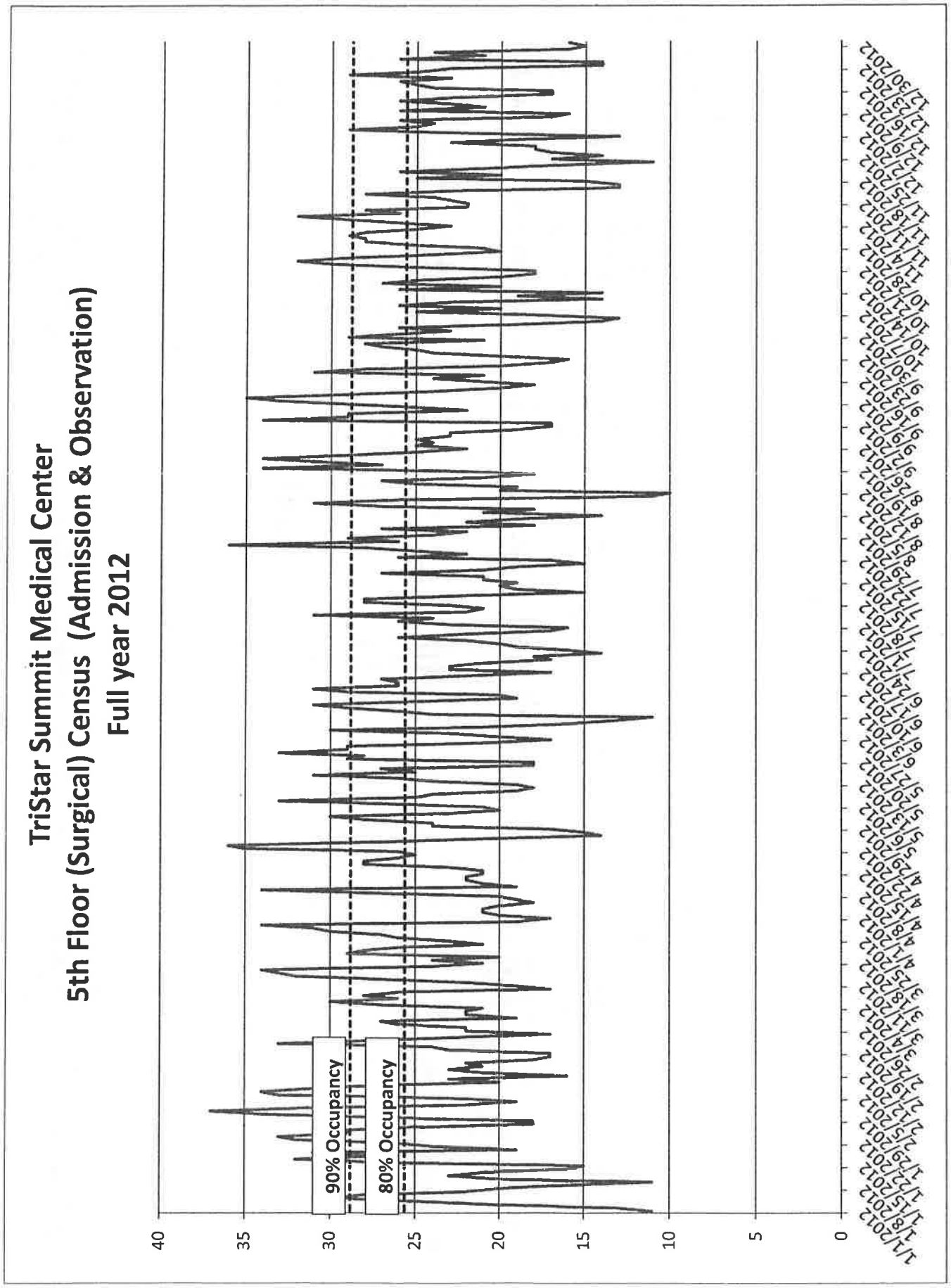
It was correct. The actual demand for acute rehabilitation in the service area in 2011 was for 44,086 days of care, because that is what was actually provided in area hospitals.

That number of days would have required 151 beds operating at 80% occupancy—twice as many beds as the Guideline bed need formula says are needed. The calculation is:

Step One: 44,086 patient days / 365 days per year = an average daily census of 120.8 patients;

Step Two: 120.8 patients per day required 151 beds, at 80% occupancy (120.8 / 80% = 151). Turning that around, 151 beds X 80% occupancy = 120.8 patients cared for.


TriStar Summit Medical Center
Medical-Surgical Census (Admission & Observation)
Full year 2012
90% Occupancy
80% Occupancy
130
120
110
100
90
80
70
60
50


TriStar Summit Medical Center
5th Floor (Surgical) Census (Admission & Observation)
Full year 2012
90% Occupancy
80% Occupancy
40
35
30
25
20
15
10
5
0

7. **Need, Item 1. (Service Specific Criteria-Comprehensive Inpatient Rehabilitation Services, #6)**
a. The applicant states the "Southern Hills' unit has grown in utilization so rapidly that the HSDA recently approved it to add four more rehabilitation beds (by conversion) regardless of the rehabilitation bed need criteria in the guidelines." . Please clarify this statement. Please provide the Project Name and Number of the referenced project.

Southern Hills received CN1111-048 to add 4 rehabilitation beds to its 8-bed unit; the additional 4 beds opened in early 2013.

The TDH and HSDA staff reviews for that project showed no rehabilitation bed need under the Guideline's rehabilitation bed need formula. Yet need existed. The circumstances at the time were compelling. Southern Hill's first 8 rehabilitation beds achieved 77% occupancy in the fifth month after opening, and on several days during that period were 100% full, with patients waiting for admission. The occupancy of the three other providers in that project's service area exceeded 74%. The HSDA found that the project was needed, and approved the addition of four rehabilitation beds within the facility's existing bed license.

b. Please indicate if McFarland Specialty Hospital is associated with a general hospital.

It is associated with University Medical Center in Lebanon. The two facilities' 2011 Joint Annual Reports state that both are in the Hospital Management Associates health system, that they have the same administrator, and that the same LLC owns their land and buildings.

SUPPLEMENTAL

c. The applicant states driving away from Nashville to rural Lebanon (for rehab services) is not a reasonable option. Please clarify if McFarland Specialty Hospital is located in a rural or urban setting. What is the population of Lebanon and Wilson County and their statewide population ranking?

(1) Population and rankings: The U.S. Census Bureau's QuickFacts website estimates Lebanon to have had a population of 26,770 in CY2011, and estimates Wilson County to have had a population of 118,961 in CY2012. See attachments following this page.

The most recent (2008) TDH projections forecast that Wilson County would have 16,150 residents in CY2013. The CY2013 forecast ranks Wilson County #16 in population, Statewide.

(2) "Rural" vs. "Urban" (application page 24).

The sentence as submitted reads "...for these patients, driving away from Nashville *to rural Lebanon* is not a reasonable option."

Because McFarland is within the city limits of Lebanon, and "rural" technically means outside the city limits of a town, it would have been more accurate to say "...for these patients, driving away from Nashville "*into more rural Wilson County* " is not a reasonable option."

While the designated "Nashville Metropolitan Statistical Area" includes Wilson County, it also includes counties such as Cannon, Cheatham, Dickson, Hickman, Macon, Smith, and Trousdale. The applicant believes that most people consider those, and Wilson, to be more "rural" counties compared to Davidson County.

d. The applicant states "see McFarland's 2011 Joint Annual Report." Please indicate where this report is located in the application.

Because 2008-2011 Joint Annual Reports (JAR's) are posted on the Tennessee Department of Health website, CON applicants have not been required to attach JAR's. So McFarland's 2011 JAR was not included in the application document.

SUPPLEMENTAL

8. Need, Item 1. (Service Specific Criteria-Comprehensive Inpatient Rehabilitation Services, #6)

The applicant states "staffing requirements and resources for the project are set forth in response C.15 below. Please indicate the location of C.15 in the application.

Please forgive this incorrect reference on page 24. That information is in Section C(III)3, page 64 of the application. A revised page 24R correcting that reference is attached following this page.

9. Need, Item 1. (Service Specific Criteria-Acute Care Services, #2)

In table Nine, the applicant appears to have used 2012-2016 TN Department of Health Bed Need Projections in parts of the table. Please verify and revise.

Attached following this page is a revised Table Nine, p. 25R, with the three "bed surplus" cells updated to the 2013-2017 projection. The other data in the table are the most current 2013-2017 projection data. The result of this update is a slightly smaller acute bed bed surplus in the service area, but no significant change in the percentages by which Summit's project will reduce that surplus.

SUPPLEMENTAL

10. Section C, Need, Item 2.
The applicant references in the application HCA TriStar's long-term plan to distribute acute rehabilitation services to suburban locations closer to patient's homes. Please discuss this plan and timeframe of implementation.

This project supports HCA TriStar's long-term plan to provide a wide range of acute hospital services in HCA hospitals across the Nashville Metropolitan Area. Broad distribution of rehabilitation care provides a fuller continuum of acute care for patients who have chosen HCA TriStar community hospitals as their facilities of choice. Where possible, the plan calls for redistribution of HCA's own licensed beds, from underutilized locations to locations with need--so that the redistributions do not increase areawide licensed bed complements.

The plan is a long-standing commitment, but without a specific timetable. Past CON approvals have allowed HCA TriStar facilities to implement that plan in each sector of Davidson County and surrounding areas--except on the eastern side--without addition of hospital beds to the service area. With CON approvals, TriStar Skyline & TriStar Horizon implemented inpatient rehabilitation several years ago in northern Davidson County and in Dickson County just east of Nashville. TriStar Southern Hills Medical Center has received CON approval twice for rehabilitation beds in southern Davidson County.

The next stage of the distribution plan is the establishment of acute inpatient rehabilitation services at TriStar Summit Medical Center, to fill a void in such care in the eastern sector of Davidson County and in western Wilson County around the community of Mt. Juliet. Again, this project will actually decrease the area's total licensed hospital beds by 1%, while increasing the area's designated rehabilitation beds by less than 1%.

11. Section C, Need, Item 3
The applicant states Summit Medical Center receives approximately 82% of its admissions from Davidson and Wilson counties. Please re-verify this percentage by referencing the 2011 JAR.

Please see the response to question #3 above, which responds to this question.

SUPPLEMENTAL

12. Section C, Need, Item 4.B.
Please verify if there are any federal designated medically underserved areas in the proposed service area.

Attached following this page are excerpts from the Federal website listing several medically underserved areas within Davidson and Wilson County. The applicant does not know where these areas are within the counties.

13. Section C, Need, Item 5
a. Please discuss existing rehabilitation beds in Davidson County that are not available to patients due to serious facility licensure issues or due to a lack of need in their current location.

There are 10 unstaffed rehabilitation beds at the TriStar Skyline Medical Center satellite campus in Madison. Shortly after HCA acquired the hospital several years ago, it suspended admissions to its medical-surgical beds pending a facility evaluation for licensure and design issues. Without acute care patients being discharged to its rehabilitation unit, the hospital had no justification for continuing to staff its rehabilitation unit. Greater need for rehabilitation services was then demonstrated at Skyline's main campus several miles north of Madison; so many of Skyline Madison's rehabilitation beds were transferred to that main campus pursuant to approved CON applications.

There are 31 non-operational rehabilitation beds at Nashville Rehabilitation Hospital (NRH). At NRH's request, on January 21, 2010, the Board for Licensing Healthcare Facilities put NRH's 31-bed license into "inactive status" for a two-year period. On Feb. 7, 2013, the Board extended that status for one more year. See documentation attached after your question 3.b above. The TDOH website indicates that NRH has not filed a Joint Annual Report since 2008. Its phone number has been disconnected.

The applicant will not comment more specifically on potential licensure issues at the NRH facility, but many building deficiencies were described to the HSDA staff and Board by parties contracted to NRH, in the March 23, 2011 Board hearing of CN1012-055 for Middle Tennessee Rehabilitation Hospital, Inc. Please see HSDA files on that project.

SUPPLEMENTAL

Beech Grove Division Service Area	03254	MUA	42.30	1994/05/12	
Crockett County					
Crockett County	03185	MUA	61.00	1984/05/18	2012/05/14
MCD (?) Unknown					
Cumberland County					
Cumberland Service Area	03186	MUA	55.20	1978/11/01	
MCD (?) Unknown					
Davidson County					
Bordeaux/Inglewood	03242	MUA	61.00	1994/05/04	2008/03/27
CT 0101.05					
CT 0101.06					
CT 0109.03					
CT 0109.04					
CT 0110.01					
CT 0110.02					
CT 0113.00					
CT 0114.00					
CT 0117.00					
CT 0118.00					
CT 0119.00					
CT 0121.00					
CT 0122.00					
CT 0126.00					
CT 0127.01					
CT 0127.02					
CT 0128.01					
CT 0128.02					
CT 0192.00					
CT 0193.00					
Davidson Service Area	03243	MUA	48.27	1982/05/10	1994/05/04
CT 0160.00					
CT 0161.00					
CT 0162.00					
CT 0163.00					
CT 0164.00					
CT 0168.00					
CT 0169.00					
CT 0170.00					
CT 0171.00					
Davidson Service Area	03248	MUA	57.06	1994/07/12	
CT 0136.01					
CT 0136.02					
CT 0137.00					
CT 0139.00					
CT 0142.00					
CT 0143.00					
CT 0144.00					
CT 0148.00					
CT 0194.00					
CT 0195.00					
Decatur County					
Decatur Service Area	03187	MUA	52.20	1978/11/01	
MCD (?) Unknown					
DeKalb County					
Dekalb Service Area	03188	MUA	60.10	1978/11/01	
MCD (?) Unknown					
Dickson County					
Charlotte Service Area	03264	MUA	0.00	1994/05/12	
Dyer County					
Mississippi-Obion Service Area	03271	MUA	56.00	1994/07/12	
Newbern Service Area	03272	MUA	60.30	1994/07/12	
Fayette County					
Fayette Service Area	03189	MUA	32.80	1978/11/01	
MCD (?) Unknown					
Fentress County					
Fentress Service Area	03190	MUA	50.10	1978/11/01	
MCD (?) Unknown					
Franklin County					
Franklin Service Area	03191	MUA	44.70	1978/11/01	
MCD (?) Unknown					
Gibson County					
Gibson Service Area	07035	MUA	55.80	1978/11/01	
MCD (?) Unknown					
Giles County					
Giles Service Area	03192	MUA	51.90	1978/11/01	
MCD (?) Unknown					
Grainger County					
Grainger County	03193	MUA	59.70	1978/11/01	2012/05/14
MCD (?) Unknown					
Greene County					
Baileyton Division Service Area	03255	MUA	56.53	1994/05/12	
Mohawk Division Service Area	03256	MUA	56.60	1994/05/12	
Grundy County					
Grundy Service Area	03194	MUA	46.10	1978/11/01	
MCD (?) Unknown					
Hamblen County					
Whitesburg Service Area	07497	MUA	61.30	1994/05/12	
Hamilton County					
Hamilton Service Area	03244	MUA	56.43	1982/06/03	1994/05/04

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home

Find Shortage Areas

HPSA & MUA/P by Address

HPSA by State & County

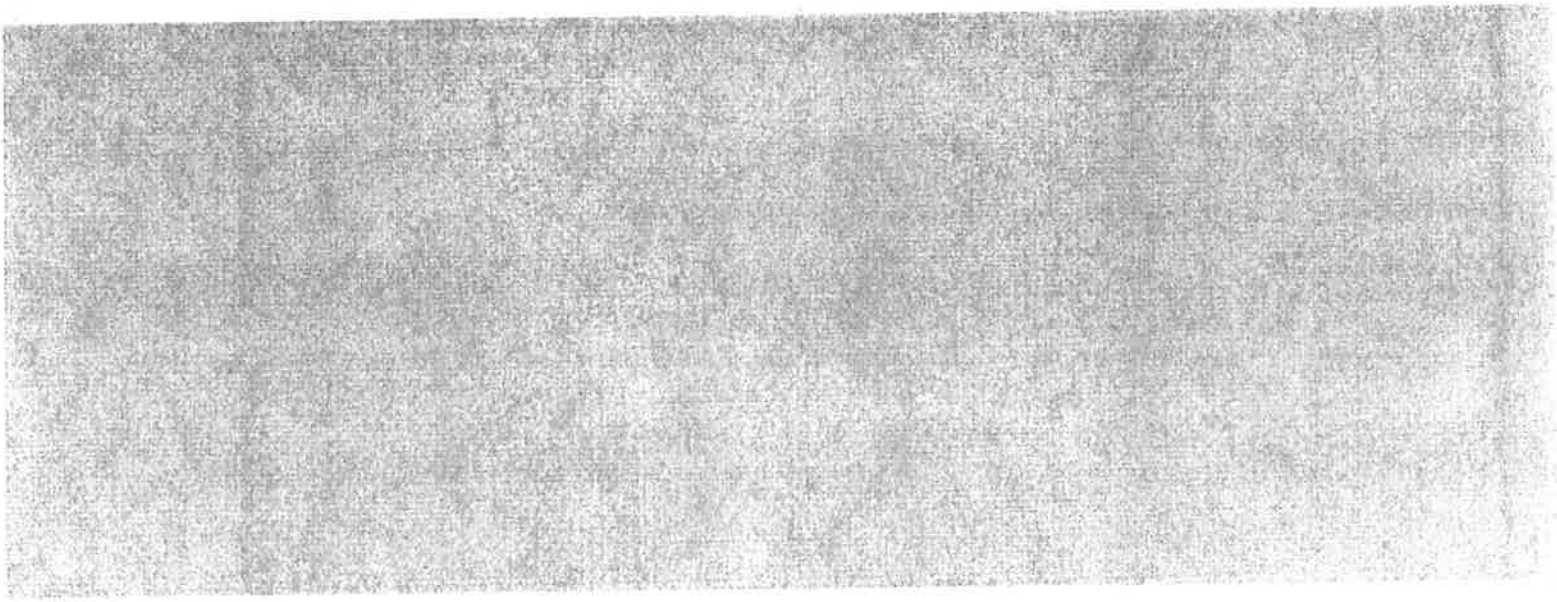
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Tennessee
County: Wilson County
ID #: All

Results: 2 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Wilson County					
Wilson Service Area	03240	MUA	54.40	1978/11/01	
MCD (?) Unknown					

NEW SEARCH | MODIFY SEARCH CRITERIA



SUPPLEMENTAL

b. In table Eight-B on page 36 of the application, the applicant states the table reflects inpatient facilities that have reported 2012 Joint Reports. A query of the Tennessee Department of Health's web-site reflects there are no 2012 JAR reports on file for Skyline Medical Center and Southern Hills Medical Center. Please clarify.

TDH assigns differing filing dates for Tennessee hospitals' 2012 Joint Annual Reports ("JAR's"). Both those hospitals have been assigned a filing date of May 29, 2013. Once submitted, the May batch of JAR's will be reviewed by TDH staff for several weeks before being posted on the TDH website. The Skyline and Southern Hills statistics in this application were provided directly to Summit by those affiliated HCA hospitals. The data are not from draft JAR documents; but their JAR's when filed should reflect the same data.

14. Section C, Need, Item 6.
On page 38 the applicant provides a table of Summit Medical Center's annual discharges to acute rehabilitation discharges for 2011 and 2012. Please provide a breakdown of where the 195 discharges were transferred to receive inpatient rehabilitation services in 2012.

Other TriStar	Baptist Rehab	McFarland	Sumner Regional	Vanderbilt Stallworth	KY Rehab	Other Rehab	TOTAL
126	4	22	3	20	1	19	195

15. Section C. Economic Feasibility Item 1 (Project Cost Chart) and Item 3
The Architect's letter in the attachments lists the construction costs as $3,293,660. However, 22,218 SF multiplied by $149.00 is $3,310,482. Please clarify.

The architect's letter is correct, and its stated construction cost is identical to line A.5, construction cost, on the Project Cost Chart.

The $149 PSF figure appears on application pages 10 and 49 as "*approximately* $149 PSF", which is correct as an approximate, rounded-up amount. The construction cost of $3,293,660, divided by the 22,218 SF of renovation, equals $148.24 PSF, which the narrative rounded up to $149 for simplicity. Attached are revised pages 10R and 49R, showing exact entries in Table Three.

SUPPLEMENTAL

16. Section C, Economic Feasibility, Item 4 (Historical Data Chart)
a. On the historical data chart, for line B.4. the applicant refers to "notes". Please indicate where these notes are located.

Those notes are on page 52, immediately following the Historic Data Chart on page 51. Page 52 is entitled "Notes to Historical Data Chart."

b. The management fees for 2011 in the Historical Data chart in the amount of $10,588,602 are not the same figures as those listed in the table on page 52 as $11,019,000. Please clarify.

The Historical Data Chart notes page (page 52) contained a spreadsheet error. Attached following this page is a revised page 52R that agrees with the management fee number in the Historic Data Chart.

c. Please explain the reason "Other Expenses" as listed in D.9 increased from $50,381,249 in 2010 to $60,000,150 in 2012.

The increase was primarily due to increases in employee benefits, professional fees, and contracted services over the two-year period.

d. Please clarify why there are no Physician Salaries and Wages assigned under D.2 in the Historical Data Chart for years 2010 through 2012.

That is because Summit does not employ physicians.

e. The table on page 52 is listed as D.8, other expenses and should be listed as D.9 other expenses. Please revise.

A revised page 52R with that correction has been submitted in response to your question 16b above.

f. (1) Please clarify how management fees are calculated.

This is a dollar amount assigned each year by the HCA corporate office to each HCA-owned hospital in the HCA system. It can be stated as an approximate per cent of net operating revenue at that hospital. The amount assigned varies each year. It is designed to cover expenses of the corporate office for management of the system. As corporate management expenses vary annually, so the management fee assigned to each hospital will vary. The applicant cannot supply Corporate's exact calculations of this expense. Please note also that these are not the same expenses as shared services like IS, billing, consulting, etc.--which are accounted for as "other expenses" in the Notes. See explanation of Parallon expenses on page 50 of the application.

f. (2) The management percentage fee of 7.2% for 2010 and 2011, and 5.8% for 2012 multiplied by Net Operating Revenue varies from the amount that is listed on page 52.

This has been amended in the revised page 52R herein submitted in response to your question 16b above.

g. Please explain the reason why management fees declined from 7.2% in 2010 to 5.8% in 2012.

They did not decline; please see the correction on revised page 52R submitted in response to your question 16b above. Over the three-year period 2010-2012, the fees were 7.24%, 6.92%, and 5.80% (rounded) of gross operating revenue. As corporate expenses vary annually, so the assigned allocation to each hospital varies.

17. **Section C, Economic Feasibility, Item 4 (Projected Data Chart)**
The management fee calculation for Year 2012 and 2015 appears to be incorrect. The management fee of 5.8% applied to Net Operating Revenue for 2014 and 2015 is $282,924 and $303,978, respectively. Please verify.

Summit Medical Center is herein amending its Projected Data Chart, the Notes page to that chart, and the response to C(II)5 with respect to that percentage. Please see revised pages 53R through 55R following this page. The hospital is projecting a management fee expense of 5.8% of net operating revenue, consistent with CY2012 experience.

SUPPLEMENTAL

18. Section C, Economic Feasibility, Item 5
The calendar years of 2013 and 2014 on the provided table do not match the years listed on the Projected Data chart. Please revise.

Please see the revised page 55R attached in response to your question #17 above.

19. Section C, Economic Feasibility, Item 6.B.
a. Please compare the applicant's proposed rehabilitation charges to McFarland Specialty Hospital's Inpatient Rehabilitation charges.

The applicant does not have access to information on McFarland's charges for rehabilitation care. That facility's Joint Annual Reports include psychiatric services along with rehabilitation services and a comparison would be meaningless.

b.The first column year of 2013 in Table Eighteen on page 57 does not match the year of 2014 in the title of the table. Please clarify.

Revised page 57R, correcting "This Project 2013" to "This Project 2014" in Table Eighteen, is attached following this page.

SUPPLEMENTAL

20. Section C, Orderly Development, Item 1.
Please list the managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual agreements for health services.

Revised page 62R is attached following this page, adding the names of the MCO's listed in Table One, page 4 of the application.

The applicant is not, and has no plans to be, a member of any alliances or networks other than the organization of HCA TriStar hospitals in Middle Tennessee.

21. Section C, Orderly Development, Item 2.
Please indicate how the proposed rehabilitation project will minimally impact non-HCA providers that provide inpatient rehabilitation services such as McFarland Specialty Hospital.

TriStar Summit Medical Center projects discharging 12 patients to McFarland Specialty Hospital in 2013, based on current trends. It is possible that due to patient choice, some of these patients would still choose McFarland even if TriStar Summit is operating an inpatient rehabilitation unit. The potential loss of no more than one patient per month would minimally impact the operations at McFarland.

22. Section C, Orderly Development, Item 3
There appears to be discrepancies with the Tennessee Department of Labor (TDOL) average clinical salaries for the Mid-State on page 64 and the proposed project clinical salaries in the table on page 65. For instance, the RN upper hourly range of $27.00 an hour is below the mean, median and experienced TDOL regional surveyed salaries. In addition, the Occupational Therapist and Social Worker wages for the proposed project appear to be above the "experienced" level of salaries. Please clarify.

Upon further research, the applicant has found more current 2012 Nashville area compensation data. Attached following this page are revised pages 64R and 65R, showing that proposed staff compensation is within the range of the published data.

SUPPLEMENTAL

23. Section C, Orderly Development, Item 4
Please indicate the plans for the staff of the current Summit inpatient psychiatric unit.

Staff members have been notified of the potential closure of psychiatric services. Summit will continue to offer psychiatric services until this CON has been granted. At that time, we will begin transitioning patients and staff to other facilities of their choice. Summit will place all affected staff members at another HCA TriStar facility if feasible, endeavoring to do this in a coordinated, timely fashion. Appropriate coordination with other parties will take place to assure that timely and adequate notice is provided to the public and to stakeholders including EMS personnel.

24. Section C, Orderly Development, Item 7 (d)
The copy of the most recent Joint Commission Survey is noted. Please provide documentation that all identified Joint Commission deficiencies were addressed through an approved plan of correction.

Documentation is attached following this page.

25. Affidavit
A signed and notarized affidavit must be submitted with each filing of an application and supplemental information. An affidavit was not included with this application. Please submit a completed affidavit for the original application and one for the supplemental information. Please note there is an affidavit form for the original filing and a separate form for supplemental responses.

The required affidavit for the original submittal was hand-delivered to HSDA on Monday, April 15. The required affidavit for these supplemental responses is attached at the end of this letter.

The Joint Commission

January 2, 2013

Jeff Whitehorn
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Joint Commission ID #: 7806
Program: Hospital Accreditation
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 01/02/2013

Dear Mr. Whitehorn:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning May 26, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

The Joint Commission

SUPPLEMENTAL

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Organization Identification Number: 7806

Evidence of Standards Compliance (45 Day) Submitted: 7/22/2012

Program(s)
Hospital Accreditation

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

You will have follow-up in the area(s) indicated below:

- Measure of Success (MOS) – A follow-up Measure of Success will occur in four (4) months.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission

SUPPLEMENTAL

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Organization Identification Number: 7806

Evidence of Standards Compliance (60 Day) Submitted: 8/16/2012

Program(s)
Hospital Accreditation

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

SUPPLEMENTAL

The Joint Commission

August 16, 2012

Re: # 7806
CCN: #440150
Program: Hospital
Accreditation Expiration Date: May 26, 2015

Jeff Whitehorn
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, Tennessee 37076

Dear Mr. Whitehorn:

This letter confirms that your May 22, 2012 - May 25, 2012 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on July 22, 2012 and August 16, 2012, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of May 26, 2012. We congratulate you on your effective resolution of these deficiencies.

§482.23 Condition of Participation: Nursing Services
§482.24 Condition of Participation: Medical Record Services
§482.25 Condition of Participation: Pharmaceutical Services
§482.41 Condition of Participation: Physical Environment

The Joint Commission is also recommending your organization for continued Medicare certification effective May 26, 2012. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation also applies to the following location(s):

Summit Medical Center
5655 Frist Blvd., Hermitage, TN, 37076

Summit Imaging
100 Physicians Way, Ste. 100 & 110, Lebanon, TN, 37087

Summit Outpatient Center
3901 Central Pike, Hermitage, TN, 37076

SUPPLEMENTAL

The Joint Commission

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

The Joint Commission

SUPPLEMENTAL

July 23, 2012

Jeff Whitehorn
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Joint Commission ID #: 7806
Program: Hospital Accreditation
Accreditation Activity: 45-day Evidence of Standards Compliance
Accreditation Activity Completed: 07/23/2012

Dear Mr. Whitehorn:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

SUPPLEMENTAL

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn
Consultant

AFFIDAVIT

SUPPLEMENTAL

2013 APR 19 PM 3:41

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

Summit Medical Center – Rehabilitation
4 Orthopedic Beds

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

John Wellborn
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 19 day of April, 2013, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires 6-21, 16.

CHRISTOPHER D. DOBBS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 6-21-2016

HF-0043

Revised 7/02

Copy

Supplemental #2

Summit Medical Center

CN1304-011

SUPPLEMENTAL- # 2
April 24, 2013
4:16 pm

DSG Development Support Group

2013 APR 24 PM 4:16

April 23, 2013

Phillip M. Earhart, Health Planner III
Tennessee Health Services and Development Agency
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37203

RE: CON Application #CN1304-011
Summit Medical Center--Rehabilitation Service & Bed Conversion

Dear Mr. Earhart:

This letter responds to your second request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit. Please note that some responses will be forwarded under separate cover.

1. **Section C, Need, Item 2.**
The applicant response to HCA TriStar's long-term plan to distribute acute rehabilitation services is noted. In that response the applicant stated "with CON approvals, TriStar Skyline and TriStar Horizon implemented inpatient rehabilitation several years ago in northern Davidson County and in Dickson County just east of Nashville." Please clarify the location of TriStar's Horizon Medical Center's rehabilitation beds in relation to Nashville.

TriStar Horizon Medical Center is the closest hospital to Nashville-Davidson County going west on I-40. It is 5.5 miles north of Exit 172 on I-40, in the City of Dickson. Its campus is approximately 29 miles miles and 32 minutes' drive west of I-40 Exit 196 at Bellevue, a rapidly growing area on the western edge of Davidson County. Attached following this page is a map showing its location.

2. **Section C, Economic Feasibility, Item 4 (Historical Data Chart)**
Please specify B.4. "Other Operating Revenue" on the Historical Data Chart in the amounts of $2,089,089 in 2010 and $2,369,663 in 2011.

Attached following this page are revised pages 51R and 52R, the Historic Data Chart and its Notes page. The notes provide the requested itemization.

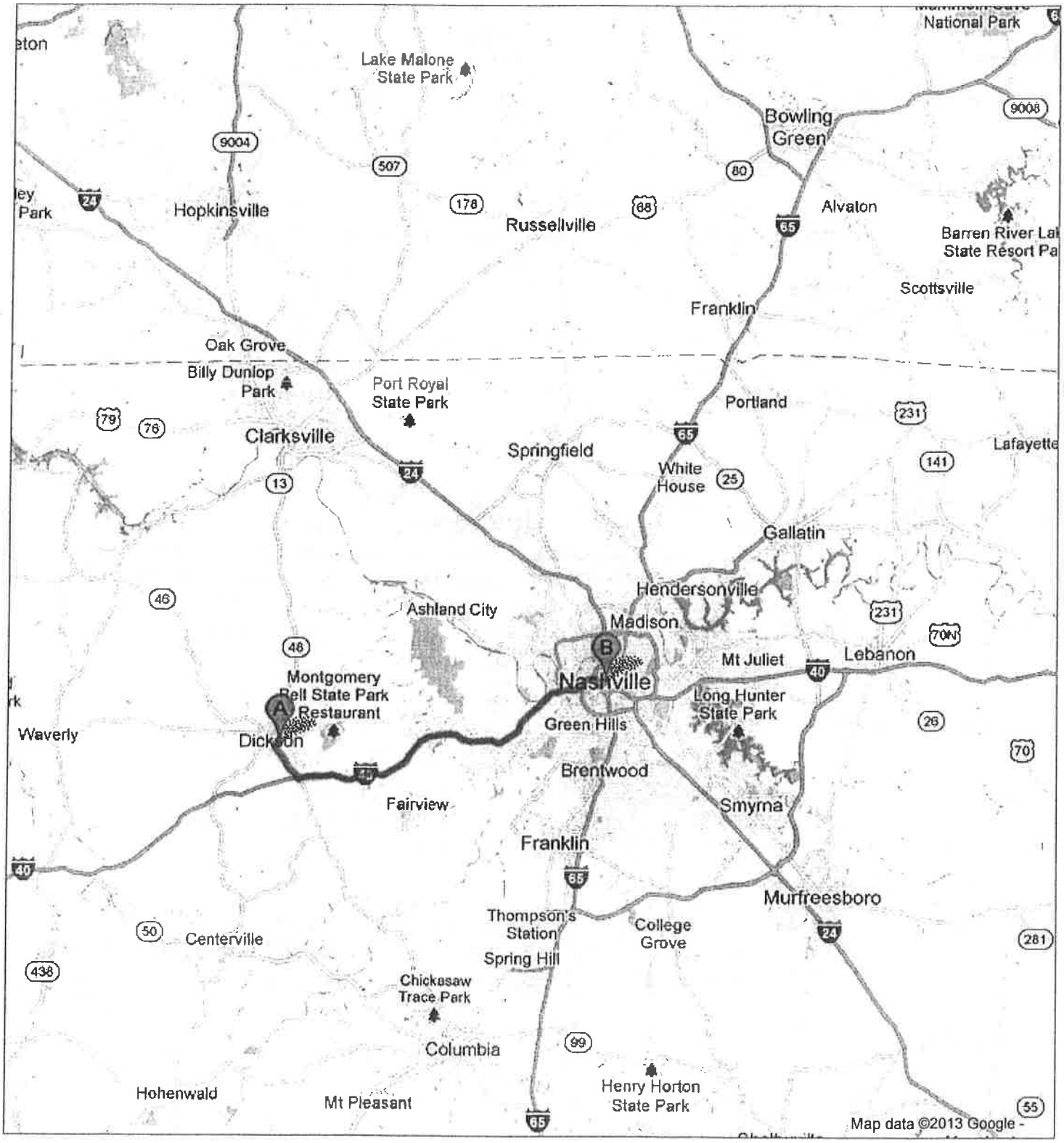
4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

SUPPLEMENTAL- # 2

April 24, 2013

To see all the details that are visible on the screen, use the "Print" link next to the map.

Google



SUPPLEMENTAL- # 2
April 24, 2013
4:16 pm

3. **Section C, Economic Feasibility, Item 4 (Projected Data Chart)**
   The Provisions for Bad Debt for the Year 2015 in the amount of $520,040 appears to be incorrect. Please verify.

   Attached following this page is revised page 53R, the Projected Data Chart, with bad debt in 2015 adjusted to $519,840. Also attached is page 55R, where two numbers in Table Seventeen changed by one digit as a result of correcting the Projected Data Chart.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

SUPPLEMENTAL- # 2
April 24, 2013
4:16 pm

AFFIDAVIT

2013 APR 24 PM 4:16

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

Summit Medical Center - Rehabilitation

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 24 day of APRIL, 2013 witness my hand at office in the County of DAVIDSON, State of Tennessee.

NOTARY PUBLIC

My commission expires 1-11-2017

HF-0043

Revised 7/02

TIFFANY B. POULOSE
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

2013 APR 8 PM 4 11

The Publication of Intent is to be published in the Nashville Tennessean, which is a newspaper of general circulation in Davidson County, Tennessee, on or before April 10th, 2013, for one day.

---

interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to convert eight (8) inpatient psychiatric beds to medical-surgical beds, and to convert twelve (12) inpatient psychiatric beds into a new twelve (12) bed acute inpatient rehabilitation unit and service at its campus, at 5655 Frist Boulevard, Hermitage, TN 37076. Inpatient psychiatric services will no longer be provided at Summit Medical Center. The estimated capital cost is $5,000,000.

TriStar Summit Medical Center is a general hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 188 hospital beds. The project will not change its licensed hospital bed complement. It will not initiate or discontinue any health service other than described above, or add any major medical equipment. Upon opening of the Summit rehabilitation unit, TriStar Skyline Medical Center will delicense ten (10) acute inpatient rehabilitation beds at its satellite campus at 500 Hospital Drive, Madison, TN 37115.

The anticipated date of filing the application is on or before April 15, 2013. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 203, Nashville, TN 37215; (615) 665-2022.

John L. Wellborn 4-8-13 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

Letters of Opposition

Summit Medical Center

CN1304-011

MARK PODY
STATE REPRESENTATIVE
46TH LEGISLATIVE DISTRICT
CANNON, DEKALB AND WILSON COUNTIES

203 WAR MEMORIAL BUILDING
NASHVILLE, TENNESSEE 37243-0146
(615) 741-7086
TOLL FREE: 1-800-449-8366 EXT. 1-7086
FAX (615) 253-0206

E-MAIL:
rep.mark.pody@capitol.tn.gov

2013 JUL 9 AM 9 31

House of Representatives
State of Tennessee

NASHVILLE

DISTRICT OFFICE:
113 South Cumberland Street
LEBANON, TENNESSEE
37087

Vice Chairman
Consumer & Resources Committee

Member of Committee
Business & Utilities

Consumer & Resources Sub

Fiscal Review Committee

July 2, 2013

Ms. Melanie Hill, Executive Director
State of Tennessee
Health Services Development Agency
Frost Building, Third Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

Dear Melanie:

As the State Representative of District 46, I wrote you last August expressing my opposition to a Certificate of Need application filed by HCA on behalf of Summit Medical Center to establish an impatient rehabilitation center. HCA has filed yet another Certificate of Need application to establish an inpatient rehabilitation center at Summit Medical Center, and nothing has changed since my last letter to you. Although the current Certificate of Need application requests a 12 bed inpatient rehabilitation unit as opposed to last year's request for a 20 bed unit, the establishment of any new inpatient rehabilitation units within University Medical Center's service area would be devastation to UMC's rehabilitation operations. I understand that currently between 15% and 20% of UMC's rehabilitation patients come from Summit Medical Center. The loss of those patients, as well as other Wilson county residents who may go to Summit Medical Center for rehabilitation treatment, would be potentially devastating to UMC's rehabilitation facility, and the loss of that facility would be damaging to the community.

I also understand that all of the rehabilitation units in and around Davidson County are capable of handling additional patients. Because of the large number of available rehabilitation beds in the greater Nashville area, and given the likely detrimental effect additional rehabilitation beds would have on UMC's existing rehabilitation unit, I strongly urge the Tennessee Health Services and Development Agency to deny the Certificate of Need application for Summit Medical Center.

Thank you for your time and consideration in this matter.

Sincerely,

Mark A. Pody
State Representative

MAP:ds

Cc: John Wellborn
Development Support
4219 Hillsboro Road, Suite 230
Nashville, TN 37215

LAW OFFICES
GKH
GRANT KONVALINKA & HARRISON, P.C.

2013 JUL 9 AM 9 31

Ninth Floor, Republic Centre
633 Chestnut Street
Chattanooga, Tennessee 37450-0900

Telephone 423/756-8400
Facsimile 423/756-6518
www.gkhpc.com

July 8, 2013

Ms. Melanie Hill, Executive Director
State of Tennessee
Health Services & Development Agency
Frost Building, Third Floor
161 Rosa L. Parks Blvd.
Nashville, Tennessee 37243

VIA FEDEX

Re: HCA Summit Medical Center Certificate of Need No. CN1304-011

Dear Ms. Hill:

Enclosed are letters of opposition to the captioned Certificate of Need for or on behalf of University Medical Center, Dr. Harvill Eaton, Dr. Thomas Scott Baker, Dr. Jon P. Cornelius, and Representative Mark Pody.

Sincerely,

J. Scott McDearman

Enclosures
cc: Mr. Matt Caldwell
Mr. Michael Cherry
Mr. John Wellborn

P:\Folders I-Z\u163\001\CON Opposition\2013-07-08 Hill ltr (2).doc

LAW OFFICES
GKH
GRANT KONVALINKA & HARRISON, P.C.

Ninth Floor, Republic Centre
633 Chestnut Street
Chattanooga, Tennessee 37450-0900

Telephone 423/756-8400
Facsimile 423/756-6518
www.gkhpc.com

July 8, 2013

Ms. Melanie Hill, Executive Director
State of Tennessee
Health Services & Development Agency
Frost Building, Third Floor
161 Rosa L. Parks Blvd.
Nashville, Tennessee 37243

VIA FEDEX

Re: HCA Summit Medical Center Certificate of Need No. CN1304-011

Dear Ms. Hill:

This firm represents University Medical Center ("UMC") in connection with opposing part of the certificate of need application filed by HCA Summit Medical Center ("HCA Summit") to convert 20 adult psychiatric beds to an 8-bed orthopedic surgical unit and a new acute care inpatient rehabilitation unit consisting of 12 beds. UMC is a 245-bed full service acute care hospital located in Lebanon, Tennessee, about 20 miles from HCA Summit. UMC operates a 26-bed rehabilitation unit, and is the only inpatient rehabilitation provider in Wilson County. UMC opposes only the rehabilitation unit portion of the application.

In September of 2012, we wrote on behalf of UMC to oppose HCA Summit's certificate of need application to establish a 20-bed inpatient rehabilitation unit. Both the prior application and the current application propose replacing HCA Summit's 20 inpatient psychiatric beds and shipping its psychiatric patients to HCA Skyline Medical Center campus in Madison, northeast of Nashville. The Agency denied HCA Summit's prior application at its September, 2012 meeting, finding that the application demonstrated neither need nor a contribution to the orderly development of health care in Tennessee. Although the current application proposes 12, rather than 20, new rehabilitation beds, the Davidson-Wilson County service area continues to have an abundance of available inpatient rehabilitation beds. No need exists for the new unit, the additional unit would only harm existing providers, and therefore it would not contribute to the orderly development of health care in Tennessee.

HCA Summit's CON application alleges that "Davidson County's net increase in rehabilitation beds will be only two (2) beds, or 1% of the total 202 beds currently approved for that county." (Page 7 of the Application.) The application also argues, at page 22, that 41

of the 202 approved rehabilitation beds are not open and are not likely to reopen, so that only 161 beds are actually available. The applicant contends that because TriStar Skyline Medical Center will de-license 10 rehabilitation beds at its Madison campus, the applicant's proposed inpatient rehabilitation unit will result in an increase of only two beds. In fact, the Skyline campus beds are among the 41 beds which are currently unstaffed. Accordingly, the establishment of the new unit would add 12 additional staffed rehabilitation beds to the service area.

The Guidelines for Growth provide that additional inpatient rehabilitation beds should not be approved unless all existing units are utilized at the following levels:

20-30 bed units - 75%
31-50 bed units - 80%
51 + bed units - 85%

As the application notes, through 2011, the last year for which all existing rehabilitation facilities reported, none of the existing units reached the Guidelines for Growth threshold utilization. UMC's rehabilitation facility continues to maintain a utilization rate of approximately 29%.

The application states that only 3% of UMC's total admissions (both psychiatric and rehabilitation) came from Davidson County in 2011. However, as the applicant notes in its first supplemental materials, HCA Summit discharged 22 of its rehabilitation patients to UMC in 2012. Further, despite HCA Summit's projection that it will discharge 12 patients to UMC's rehabilitation unit in 2013, based on admissions from HCA Summit thus far, UMC will receive 34 patients from the applicant this year. At that rate, discharges from HCA Summit will result in over 17% of UMC's inpatient rehabilitation admissions. The loss of virtually all of those patients so that HCA Summit can keep the patients in-house would be devastating to UMC and threaten the existence of its inpatient rehabilitation unit.

The citizens of Wilson County rely on UMC's rehabilitation unit. The loss of the facility would mean more than just additional drive time for patients' family members. The loss could cost the area jobs, and result in the loss of trained medical personnel from Wilson County.

No need existed for additional inpatient rehabilitation beds in Davidson or Wilson County in September of 2012. Need has not increased in the subsequent 10 months. In fact, based on pending changes in federal reimbursement as well as a developing pattern of discharging patients to home health and other options besides inpatient rehabilitation care, the utilization of existing beds will likely decrease in the future. Adding additional inpatient rehabilitation beds in the absence of a genuine need for those beds adversely impacts existing providers and puts a strain on limited medical resources. The addition of rehabilitation beds

will therefore adversely impact the orderly development of health care in Davidson and Wilson counties. Accordingly, we respectfully request that the Agency deny the HCA Summit application for a certificate of need for the establishment of an inpatient rehabilitation unit.

Sincerely,

J. Scott McDearman

P:\Folders I-Z\u163\001\CON Opposition\2013-07-01 Hill ltr re UMC's opposition to CON.doc

cc: Mr. Matt Caldwell
Mr. Michael Cherry
Mr. John Wellborn

2013 JUL 9 AM 9 31

Office of the President

CUMBERLAND UNIVERSITY

July 2, 2013

Ms. Melanie Hill, Executive Director
State of Tennessee
Health Services and Development Agency
Frost Building, Third Floor
161 Rosa L. Parks Blvd.
Nashville, Tennessee 37243

Dear Ms. Hill:

I understand that at its July 24 meeting the Health Services and Development Agency will consider Summit Medical Center's certificate of need application to operate a 12-bed inpatient rehabilitation unit. Because the establishment of the proposed rehabilitation unit would severely damage the only existing rehabilitation unit in Wilson County, I strongly urge you to reject the application.

I am fortunate to serve as both Chairman of the University Medical Center's ("UMC") Board of Trustees and as President of Cumberland University in Lebanon. In my role with the Board at UMC, I recognize that our rehabilitation unit operates at just under 30% of capacity. Any reduction in use of UMC's rehabilitation facility could spell the end of its operations. While Summit Medical Center currently sends 20 to 35 rehabilitation patients to UMC each year, we are under no illusion that Summit will continue to send any patients to UMC if it is allowed to operate its own rehabilitation unit. The citizens of Wilson County depend on this unit, and its demise would be damaging to the community.

Additionally, in connection with my position at Cumberland University, I understand the importance of the continued operation of the UMC rehabilitation unit to Cumberland's nurse training program. We send nurses though a rehabilitation rotation each semester, and for many of them it would be impractical to travel to rehabilitation facilities outside of Wilson County to further their education.

Nashville and Wilson County have an excess capacity of rehabilitation beds. Allowing the establishment of a new rehabilitation unit at the eastern edge of Davidson County would likely result in severe damage to University Medical Center's rehabilitation unit, as well as hurt the nurse training program at Cumberland University. We therefore strongly request that you deny Summit Medical Center's certificate of need application. Thank you for your consideration.

Sincerely,

Harvill Eaton

Harvill C. Eaton, Ph.D.

cc: Mr. Matt Caldwell
Mr. Michael Cherry
Mr. John Wellborn

One Cumberland Square • Lebanon, Tennessee 37087 • Telephone (615) 547-1223 • Fax (615) 453-6653 • eaton@cumberland.edu

Tennessee Physical Medicine and Pain Management

2013 JUL 9 AM 9 31

T. Scott Baker, M.D. **Steven A. Urban, M.D.**

Board Certified in Physical Medicine & Rehabilitation, Pain Medicine, and Electrodiagnostic Medicine

PO Box 1165, 1423 W. Baddour Parkway, Lebanon, Tennessee 37087, phone 615-257-0900, fax 615-443-1444

Baptist Office: 2021 Church Street, Baptist Medical Plaza II, Suite 610, Nashville, TN 37203

July 3, 2013

Ms. Melanie Hill, Executive Director
State of Tennessee
Health Services Development Agency
Frost Building, Third Floor
161 Rosa L. Parks Blvd.
Nashville, Tennessee 37243

Dear Ms. Hill:

Last August, I wrote to you expressing my opposition to a Certificate of Need application filed by HCA on behalf of Summit Medical Center to establish an inpatient rehabilitation center. HCA has filed yet another Certificate of Need application to establish an inpatient rehabilitation center at Summit Medical Center, and nothing has changed since my last letter to you. Although the current Certificate of Need application requests a 12 bed inpatient rehabilitation unit as opposed to last year's request for a 20 bed unit, the establishment of any new inpatient rehabilitation units within University Medical Center's service area would be devastating to UMC's rehabilitation operations. I understand that currently between 15% and 20% of UMC's rehabilitation patients come from Summit Medical Center. The loss of those patients, as well as other Wilson County residents who may go to Summit Medical Center for rehabilitation treatment, would be potentially devastating to UMC's rehabilitation unit. The residents of Wilson County rely on UMC's rehabilitation facility, and the loss of that facility would be damaging to the community.

I also understand that all of the rehabilitation units in and around Davidson County are capable of handling additional patients. Because of the large number of available rehabilitation beds in the greater Nashville area, and given the likely detrimental effect additional rehabilitation beds would have on UMC's existing rehabilitation unit, I strongly urge the Tennessee Health Services and Development Agency to deny the Certificate of Need application for Summit Medical Center.

Sincerely,

Thomas Scott Baker, M.D.

cc: Mr. John L. Wellborn
Development Support Group
4219 Hillsboro Road, Suite 230
Nashville, Tennessee 37215

2013 JUL 9 AM 9 31

July 3, 2013

Ms. Melanie Hill, Executive Director
State of Tennessee
Health Services Development Agency
Frost Building, Third Floor
161 Rosa L. Parks Blvd.
Nashville, Tennessee 37243

Dear Ms. Hill:

I am a practicing physician in Lebanon. This letter constitutes my objection to the Certificate of Need application filed on behalf of Summit Medical Center for the establishment of a 12 bed inpatient rehabilitation facility. I refer many of my patients who need rehabilitation services to University Medical Center's rehabilitation unit here in Lebanon. The facility provides high quality care, but is currently underutilized. I believe that allowing a new rehabilitation center inside of UMC's service area may reduce the patient census in the unit to the point that UMC can no longer maintain it. UMC has the only inpatient rehabilitation facility in Wilson County. If UMC's rehabilitation unit ceases operations because of a new rehabilitation facility in UMC's service area, the residents of Wilson County will suffer.

Neither Davidson nor Wilson County needs an additional inpatient rehabilitation facility. Existing facilities all have excess capacity to handle future patient needs. The establishment of an inpatient rehabilitation center at Summit Medical center will only damage UMC and the residents of Lebanon. I respectfully request that the Health Services and Development Agency reject Summit Medical Center's application to establish an inpatient rehabilitation unit.

Sincerely,

Jon P. Cornelius, MD
Orthopedic Surgeon

cc: Mr. John L. Wellborn
Development Support Group
4219 Hillsboro Road, Suite 230
Nashville, Tennessee 37215

Saint Thomas Health

July 9, 2013

2013 JUL 9 AM 11 32

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

RE: Summit Medical Center
CN1304-011

Dear Ms. Hill:

On behalf of Saint Thomas Health and Baptist Hospital, a part of the Saint Thomas Health network of providers, this letter is to express opposition to the Certificate of Need application for Summit Medical Center proposing to establish a new 12-bed acute inpatient rehabilitation unit that includes moving its adult psychiatric patients.

Based on review of this application, it is not clear what has changed since a very similar application was reviewed and denied at the September 26, 2012, meeting of the Health Services and Development Agency. Our concerns expressed in opposition to that application remain with this application in that the need for the proposed service is not justified and the project does not represent orderly development of healthcare for our region.

Based on review of the application and supplemental material, the following observations are offered:

- Residents of the proposed service area currently have good access to existing inpatient rehabilitation services including four providers in Davidson County and one in Wilson County with varying occupancy levels that range from 29% to 76% for these facilities. The occupancy levels of the existing programs have not significantly changed. These existing programs with capacity are located within reasonable drive times (17 to 27 minutes) from Summit Medical Center. In fact, McFarland Hospital, located in neighboring Wilson County, is underutilized with 29% occupancy in 2011. It is unclear whether Summit offers this facility as an option for its patients that are discharged to acute rehabilitation.
- The application states that need is justified because of shifting Davidson County rehabilitation admissions to suburban locations from 2008 to 2011. The data shows that the shift appears to be related to Southern Hills Medical Center opening their rehab unit in 2011

affecting the volumes of the other Nashville programs. Note that the total patient days remained flat during this time with 44,290 patient days in 2008 and 44,086 in 2011.

- Since implementation of the Inpatient Rehabilitation Facilities (IRF) Prospective Payment System, the growth trend in IRF discharges ended and volume declined steadily and is now leveling. In fact, Medicare is now evaluating further reforms for payment of post-acute services including payment cuts to Inpatient Rehabilitation Hospitals, equalizing payments across settings (inpatient rehab vs. skilled nursing facilities), reinstating the 75% rule, and eventually initiating bundled payments for post-acute care providers. While the impact of these proposals is unknown, we do know that these can all have a detrimental impact on inpatient rehabilitation making it even more important for existing providers to retain current utilization levels for financial viability. This application would erode volumes for current providers.
- The use of inpatient rehabilitation services is declining for Orthopedics patients with increasingly more patients going home with or without home health services or to skilled nursing facilities for follow-up care.
- Summit has overstated need and utilization projections for the project based on their hypothetical review of patients that met RIC criteria. When a similar analysis was done for Baptist Hospital, we found that patients for whom the analysis indicated should go to inpatient rehabilitation were actually going to lower levels of care at a rate about 20% higher than projected by Summit. Our analysis included reviewing clinical information from each patient's chart to verify whether they required the medical level of care that inpatient rehabilitation requires upon discharge.
- Summit is projecting to achieve occupancy levels in the first two years of operation of 83.25% and 87.5%, which seems unrealistic given that this level of utilization far exceeds historical occupancy levels of established providers in Nashville. In addition, the year one volume projection of 270 admissions is 38% higher than their stated discharges of 195 patients going to acute rehabilitation in 2012 – again indicative of inflated volume projections.
- The project proposes to decrease access to psychiatric services for what is typically a very fragile patient population based on a relatively lower occupancy for those beds. However, the application shows that the 2012 occupancy for its psychiatric beds at 58.8% is consistent with its overall inpatient occupancy level at 62.0% in 2012 (excluding observation days that should not be included in the inpatient occupancy calculation). The utilization of other bed categories at Summit in 2012 are notably lower with critical/intermediate beds at 54.8%, NICU beds at 20.5%, and Obstetrical beds at 34.2%. In addition, the census on Summit's psychiatric unit increased in 2011 over levels in the prior two years and the ADC for 2012 is

Saint Thomas Health

above the level in 2010. While the stated intent is to improve inpatient rehabilitation access for suburban patients, it will have the opposite impact on the suburban psychiatric patients being displaced by the proposal.

In conclusion, this application should not be approved for the following reasons relative to general criteria for CON:

Need	Need has not been substantiated in the application for additional inpatient rehabilitation capacity in the market. The proposed service area is adequately served by existing service area providers with available capacity given the trend toward use of lower levels of care and lack of any real growth in inpatient rehabilitation admissions for providers in the service area. Existing providers are not at the utilization level recommended by the Criteria and Standards for CON.
Economic Factors	Since need has not been substantiated, this duplication of available services adds an unnecessary cost burden and increases overall costs of health care for the public.
Contribution to the Orderly Development of Health Care Facilities and/or Services	The proposed facility does not contribute toward the orderly development of health care. It is not orderly development to decrease access for psychiatric patients. In addition, the projected volumes and occupancy levels are higher than would be expected given current trends and historical performance. The addition of rehabilitation beds to the market will result in decreasing utilization for existing providers.

Based on the considerations set forth in this letter, we respectfully request the Health Services and Development Agency reject this application for Summit Medical Center.

Respectfully,

Barbara Houchin

Barbara Houchin
Executive Director, Planning

cc: Bernie Sherry
Matt Caldwell
Scott McDearman
John Wellborn

Deka A. Efobi
Board Certified Neurologist
Neurology Clinic & Associates, LLC
305 W. Main Street
Lebanon, Tennessee. 37087
Ph: 615-443-9912 Fax: 615-443-9978
www.bestneurologyclinic.com

July 3, 2013

Ms. Melanie Hill, Executive Director
State of Tennessee
Health Services Development Agency
Frost Building, Third Floor
161 Rosa L. Parks Blvd.
Nashville, Tennessee. 37243

Dear Ms. Hill,

I am the Medical Director for the inpatient rehabilitation unit of University Medical Center. While the rehabilitation facility provides the highest quality inpatient service, the facility is underutilized, with an average census of approximately 30% of capacity. Any reduction in use of the facility could result in its closing, which would mean a loss for the people of Lebanon and Wilson County. I believe that the establishment of any additional inpatient rehabilitation units in or around UMC's service area will be very damaging to UMC's rehabilitation unit. For that reason, I strongly oppose the Certificate of Need application filed by HCA on behalf of Summit Medical Center for the establishment of a 12 bed inpatient rehabilitation center.

I am aware that all of the rehabilitation centers in and around Davidson County are currently underutilized. No need exits, either in Davidson or Wilson counties, for any additional inpatient rehabilitation beds. I am also aware that Summit Medical Center referred 22 patients to UMC's inpatient rehabilitation unit last year and is on track to refer 34 patients this year. The loss of those referrals, along with the business from other patients in western Wilson County, could easily put UMC's inpatient rehabilitation facility out of business. The loss of that business would result in job losses to employees who work at UMC and unnecessary inconvenience and travel for families of rehabilitation patients in and around Lebanon and Wilson County.

Approval of Summit Medical Center's Certification of Need would be harmful to UMC and the citizens of Wilson County. Please reject Summit Medical Center's application.

Deka Efobi MD

Cc: Mr. John L. Wellborn
Development Support Group
4219 Hillsboro Road
Nashville, TN 37215

HEALTHSOUTH

July 10, 2013

Melanie Hill, Executive Director
Health Services and Development Agency
State of Tennessee
Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

RE: Summit Medical Center – CN1304-011

Dear Ms. Hill:

HealthSouth Corporation (HealthSouth) opposes the CON Application (CN1304-011) filed by Summit Medical Center (Summit) to convert twelve (12) inpatient psychiatric beds into a new twelve (12)-bed inpatient rehabilitation unit at the campus of TriStar Summit Medical Center at 5655 Frist Boulevard, Hermitage, Davidson County, Tennessee, 37076. HealthSouth operates six (6) freestanding inpatient rehabilitation hospitals in Tennessee, including Vanderbilt Stallworth Rehabilitation Hospital, L.P., in Davidson County. HealthSouth also has approval to establish another freestanding inpatient rehabilitation hospital in Williamson County that is currently under appeal.

HealthSouth respectfully submits that, on the merits, this application should be denied because there is no need for the project, and the project does not contribute to the orderly development of health care. The Tennessee Guidelines for Growth for Comprehensive Inpatient Rehabilitation Services state that "additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:...51 bed plus unit/facility ~ 85%."

This guideline is not met. For 2012, Vanderbilt Stallworth Rehabilitation Hospital provided 22,922 days of care for an average daily census of 62.6 patients. Based on eighty (80) licensed beds, its occupancy percentage for 2012 was 78.3%, well below the 85% threshold.

HealthSouth believes that comprehensive inpatient rehabilitation services are best provided in freestanding facilities. There are no special services a comprehensive inpatient rehabilitation unit at Summit could offer that are not offered at Vanderbilt Stallworth. To be eligible for Medicare reimbursement as an inpatient rehabilitation facility (IRF), 60 percent of the patients admitted to an IRF must have a medical condition classified within one or more of 13 conditions, commonly known as the "CMS-13", established by the Centers for Medicare and Medicaid Services ("CMS") that indicate a need

3660 Grandview Parkway, Suite 200 • Birmingham, AL 35243
205 967-7116 • Fax 205 262-8708
www.healthsouth.com

for intensive rehabilitative services. The CMS-13 include: stroke, spinal cord injury, neurological disorders, burns, active polyarthritis, systemic vasculidities, advanced osteoarthritis, knee or hip replacement with additional co-morbidities, amputation, brain injury, congenital deformity, fracture of femur and major multiple trauma. It will be difficult for Summit to meet the 60% rule and achieve a reasonable occupancy on twelve (12) beds.

In addition, information contained in a March 2013 Medpac publication shows that inpatient rehabilitation units are more expensive to operate than freestanding hospitals. After finding that inpatient rehabilitation units and freestanding inpatient rehabilitation hospitals serve similar patient populations, Medpac concluded that "[O]n average, after adjustment, costs per discharge in freestanding IRFs were about $4,340 lower (26 percent) than in hospital-based IRFs...Larger facilities have lower costs per discharge, which likely results from economies of scale. In 2011, costs per discharge were $5,320 ((29 percent) lower in facilities with more than 60 beds compared with facilities in the 1-bed to 10-bed range."[1] Further, "[N]early all facilities (96 percent) in the highest cost quintile were hospital based, whereas facilities in the lowest cost quartile were disproportionately freestanding (about 56 percent were freestanding even though they make up only 20 percent of industry facilities). IRFs in the lowest cost quartile tended to have more beds and higher occupancy rates."[2] (Ibid.)

For all the reasons discussed above, HealthSouth would again urge the Health Services and Development Agency to deny Summit Medical Center's Certificate of Need application (CN1304-011) to convert twelve (12) inpatient psychiatric beds into a new twelve (12) bed inpatient rehabilitation unit.

Sincerely yours,

Walter C. Smith
Director, State Regulatory Affairs
HealthSouth Corporation

[1] Report to the Congress: Medicare Payment Policy (March 2013). MEDPAC. pps. 228-229.
[2] Ibid. p. 229.

Letters of Support

Summit Medical Center

CN1304-011

60TH HOUSE DISTRICT
DAVIDSON COUNTY

2013 JUL 15 AM 10:23

HOUSE CHAMBER
STATE OF TENNESSEE

COMMITTEES:
HEALTH
HEALTH SUB
STATE GOVERNMENT

24 LEGISLATIVE PLAZA
NASHVILLE, TN 37243-160
PHONE: (615) 741-6959
FAX: (615) 253-0331

DARREN JERNIGAN
REPRESENTATIVE
rep.darren.jernigan@capitol.tn.gov

4837 RAINER DRIVE
OLD HICKORY, TN 37138
PHONE: (615) 847-1733

July 12, 2013

Ms. Melanie M. Hill, Executive Director
TN Health Services & Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Summit Medical Center – CN1304-011

Dear Ms. Hill,

It is my privilege to serve as the State Representative of House District 60 which encompasses a large portion of eastern Davidson County. Summit Medical Center is located in my district and plays a vital role in providing essential healthcare services to the residents of the area and beyond.

I enthusiastically support Summit's efforts to make inpatient rehabilitation services locally accessible to our citizens. While I realize there are other hospitals in downtown Nashville, and even further away in Lebanon in Wilson County which provide this service, I strongly believe the citizens of this area should at least have the choice to remain closer to their families and loved ones when they need inpatient rehabilitation services.

I know the Health Services and Development Agency must balance many considerations in its deliberations and decision-making, but it seems to me patient needs and accessibility should remain foremost among those. I urge you to approve this certificate of need, so that Summit Medical Center may continue to further its mission of meeting the health care need of the citizens it services.

Sincerely,

Darren Jernigan

DJ/pjm

Mt. Juliet Health Care Center, Inc.
(Affiliate of THM)
2650 North Mt. Juliet Road • Mt. Juliet, TN 37122
Phone: (615) 758-4100 • Fax: (615) 758-5450

Mr. Jeff Whitehorn, CEO
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Dear Jeff,

I am writing in support of Summit Medical Center's Certificate of Need (C.O.N.) application to add a twelve (12) bed inpatient rehabilitation unit. As you know, many of Mt. Juliet Health Care Center's residents receive care at Summit Medical Center and speak highly of the care and services they received. In addition, I have personally met with your leadership and know they are committed to providing high quality care.

So, I very much support the approval of your request to the State of Tennessee Health Services and Development Agency to add 12 inpatient rehabilitation beds. The Mt. Juliet Health Care Center team believes this will allow more patients to benefits from the outstanding care and services provided at Summit.

Sincerely,

Charlie Anderson
VP of SNF Operations, THM

Quality Rehab
and
Health Center
932 BADDOUR PARKWAY
LEBANON, TN 37087

JUL 18 AM 11 21

Quality Rehab and Health Center

July 15, 2013

Mr. Jeff Whitethorn
Summit Medical Center
5655Frist Blvd
Hermitage, TN 37076

Dear Jeff,

I am writing in support of your Certificate of Need to add a twelve bed inpatient rehabilitation unit. Summit is a true partner in the goal of quality care for area residents. We at Quality Rehab and Healthcare believe this service is another step towards this goal.

Rod Wolfe
Administrator

Quality Rehab
and
Health Center
932 BADDOUR PARKWAY
LEBANON, TN 37087

JUL 18 AM 11 21

July 15, 2013

Mr. Jeff Whitethorn
Summit Medical Center
5655Frist Blvd
Hermitage, TN 37076

Dear Jeff,

I am writing in support of your Certificate of Need to add a twelve bed inpatient rehabilitation unit. Summit is a true partner in the goal of quality care for area residents. We at Quality Rehab and Healthcare believe this service is another step towards this goal.

Rod Wolfe
Administrator

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF HEALTH STATISTICS
615-741-1954

DATE: July 1, 2013

APPLICANT: Summit Medical Center
5655 Frist Boulevard
Hermitage, Tennessee 37076

CONTACT PERSON: John L. Wellborn
Development Support Group
4219 Hillsboro Road, Suite 203
Nashville, Tennessee 37076

COST: $4,933,576

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's Health: Guidelines for Growth, 2011 Edition*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:
The applicant, Summit Medical Center, located in Nashville (Davidson County), Tennessee, seeks Certificate of Need (CON) approval to convert eight inpatient psychiatric beds to medical-surgical beds, and to convert twelve inpatient psychiatric beds into a new twelve bed acute inpatient rehabilitation unit and services at its campus at 5655 Frist Boulevard, Hermitage, Tennessee 37076. Inpatient psychiatric services will no longer be provided at Summit Medical Center.

TriStar Summit Medical Center is a general hospital licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities for 188 beds. The project will not change the licensed hospital bed complement. The project will not initiate or discontinue any health service other than described in this project, or add any major medical equipment. Upon the opening of the Summit rehabilitation unit, TriStar Skyline Medical Center will delicense ten acute inpatient rehabilitation beds at its satellite campus at 500 Hospital Drive, Madison, Tennessee 37115.

This project involves the renovation of 22,118 square feet of space and no new construction. The total renovation cost is $3,293,660 or $148.24 per square foot. The cost per square foot is consistent with 2009-2011 hospital projects approved by HSDA.

Summit Medical Center is an HCA TriStar facility owned by HCA Health Services of Tennessee, Inc., whose ultimate parent company is HCA, Inc. Attachment A.4 contains details, and organization chart, and information on Tennessee facilities owned by HCA.

The total estimated project cost is $4,933,576 and will be funded by a cash transfer from the applicant's parent (HCA, Inc.) to the applicant's division office (TriStar Health System.) Documentation of financing is provided in Attachment C, Economic Feasibility-2.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

NEED:
The applicant's service area consists of Davidson and Wilson counties.

The service area population for 2013 projected to 2017 is illustrated below.

County	2013 Population	2017 Population	% Increase/ (Decrease)
Davidson	605,293	622,476	2.8%
Wilson	116,150	122,658	5.6%
Total	**721,443**	**745,134**	**3.3%**

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

2011 Service Area Rehabilitation Bed Utilization

Facility	Rehab Beds	2010 Occupancy
Baptist Hospital	24	69.0%
Skyline Medical Center	41	75.5%
Vanderbilt Stallworth	80	77.6%
Southern Hills Medical Center	12	69.2%
McFarland Hospital	26	29.4%

Source: *Joint Annual Report of Hospitals 2011,* Division of Health Statistics, Tennessee Department of Health
*The 171 total beds represent only the operational beds as of the 2011 JAR. See note below.

Note to Agency Members: Nashville Rehabilitation Hospital's 31 beds are licensed "in abeyance" and have been nonoperational for several years. Skyline Madison's 10 licensed rehabilitation beds are nonoperational.

This project converts 20 adult psychiatric beds on the hospital's third floor into an 8-bed orthopedic surgical unit, and a new acute rehabilitation unit of 12 beds. This conversion does not increase the hospital's licensed bed complement. If the project is approved and completed, TriStar Skyline Medical Center will delicense 10 rehabilitation beds at its Madison campus and will take Summit's psychiatric patients into its much larger adult psychiatric program at that campus. The result of these changes will reduce the county's total licensed hospital beds by 10 beds.

The applicant's stated need for this project is summarized as follows:

- Summit Hospital's discharges to other area hospital's rehabilitation units are high due to local population growth as well as Summit's recent emergency department expansion and its designation as one of Tennessee's 18 Certified Primary Stroke Centers. In order to have a state-of-the-art full continuum of stroke treatment center, an in-house acute rehabilitation unit is needed.

- The applicant contends the utilization of available rehabilitation beds in Davidson County is at efficient levels. There are currently four operational acute care programs that have provided 41,292 days of care in 2011. The occupancy rate on the 157 rehabilitation beds that were open in 2011 was 72.1%. Nashville Rehabilitation Hospital's 31 beds are licensed "in abeyance" and have been nonoperational for several years and Skyline Madison's 10 licensed rehabilitation beds also are nonoperational. Nashville Rehabilitation's beds are unlikely to open in the near future, if at all.

- Previous CON approvals and market trends have shown a move of rehabilitation beds closer to patient's homes in suburban communities. The applicant reports total rehabilitation services provided in hospitals located in downtown Nashville have decreased by approximately 15% from 2008 to 2011, while services provided in the suburban areas has increased approximately 56%.

- Acute rehabilitation beds have been approved for the northern and southern Davidson County hospitals as well as the urbanizing areas west and south of Davidson County. The eastern portion of Davidson County has not seen the approval of rehabilitation beds. TriStar Summit Medical Center in Hermitage would be a logical consideration due to it

being the only hospital in eastern Davidson County.

- This project is for only 12 beds and will be utilized with patients who meet the requirement of being able to undergo 3 hours of rehabilitation therapies per day. The lower intensity nursing home rehabilitation programs should not be significantly impacted. These programs will continue to receive referrals from Summit. Summit Hospital plans to strengthen collaboration with area nursing homes and provides letters of support from area facilities for this project. This collaboration should provide greater efficiency and quality of care for patients than what currently exists.

- The hospital is seeking Joint Commission accreditation as a Total Joint Center of Excellence. A dedicated orthopedic nursing unit would enhance specialized nursing care and improve patient outcomes. The conversion of underutilized bed is the most logical and fastest way to achieve surgical bed capacity In CY2012, the applicant reports Summit's surgical beds averaged 78% occupancy on weekdays. On almost half of those weekdays, occupancy exceeded 80%, often reaching 100%. Medical surgical bed occupancy in 2012 was reported by the applicant to exceed 83% in 2012. In contrast, the psychiatric unit being converted had only 59% occupancy in 2012.

TENNCARE/MEDICARE ACCESS:
The applicant is both a Medicare and a TennCare provider.

The applicant anticipates approximately 3% of their patients will be TennCare with revenues of $356,400 and 52% will be Medicare with revenues of $6,177,600.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment has reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine they are mathematically accurate and the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located on page 47 of the application. The projects total estimated project cost is 4,933,576.

Historical Data Chart: The applicant provides a Historical Data Chart in Supplemental 2. The applicant reports a net operating income of $10,890,220, $12,414,115, and $18,407,255 each year, respectively.

Projected Data Chart: The Projected Data Chart is located in Supplemental 2, page 22. The applicant projects 270 admissions and 3,645 patient days in year one and 284 admissions and 3,834 patient days in year two with a net operating income of $1,579,076 and $1,716,222 each year, respectively.

The applicant's year one average gross charge in years one and is estimated to be $3,259 per day, with and average deduction of $1,921, resulting in an average gross charge of $1,338 per day. In year two, the estimated cost per day is $3,390, with an average deduction of $2,023, resulting in an average charge per day of $1,367.

The applicant reports there are no alternatives to make acute impatient rehabilitation more accessible to residents of the eastern portions suburban edge of Davidson County and adjoining western Wilson County. Acute rehabilitation and is a hospital-based program and Summit is the only hospital between the rehabilitation units at Baptist Hospital in central Davidson County and UMC McFarland Hospital in central Wilson County, a distance of 32 miles. The applicant believes deployment of rehabilitation at Summit would be consistent with HSDA decisions for other suburban areas around Nashville.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
Summit Medical Center has working relationships with the following providers: McKendree, Mt. Juliet Healthcare, Donelson Place, and Lebanon Health and Rehabilitation, Alive Hospice, Odyssey Hospice, Avalon Hospice, Asera Care Hospice, Suncrest Home Health, Gentivia Home Health, Amedysis Home Health, Walgreens Home Infusion, IV Solutions Home Infusion, Coram Home Infusion, Medical Necessities, At Home Medical, Apria, and All-Star.

Summit Medical assert this project will provide easier access to acute inpatient rehabilitation for residents of eastern Davidson County and western Wilson County who are being discharged from initial acute care stays at Davidson County hospitals, especial Summit Medical Center, who would prefer the Hermitage location to a downtown or Wilson County location.

The impact on non-HCA providers should be minimal. The project adds only a net of 2 rehabilitation beds to the service area but decreases total licensed acute care bed compliments in the area by 10 beds. The majority of Summit's discharges to acute rehabilitation programs in Nashville were to sister HCA hospitals in CY2012.

The projects impact on TriStar Medical Center's adult psychiatric program will increase efficiency and capacity of the Skyline program.

The applicant provides a listing of the anticipated staffing in Supplemental 2, page 65.

The applicant provides a listing of the schools with which Summit has affiliation agreements with on page 67 of the application.

The applicant is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and fully accredited by the Joint Commission. The applicant is also seeking accreditation as a Certified Primary Stroke Center.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition.*

COMPREHENSIVE INPATIENT REHABILITATION SERVICES

1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.

   The Division of Policy, Planning, and Assessment used the above formula to calculate a bed need of 72.1 beds based on the 2013 population of the service area.

2. The need shall be based upon the current year's population and projected four years forward.

   The Division of Policy, Planning, and Assessment used the above formula to calculate a bed need of 72.1 beds based on the 2013 population of the service area.

3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.

   Approximately 82% of Summit's admissions come from Davidson and Wilson counties and it is anticipated Summit's rehabilitation unit will come from Summit discharges.

4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.

The project is for 12 beds.

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.

Not applicable.

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:

20-30 bed unit	~ 75%
31-50 bed unit/facility	~ 80%
51 bed plus unit/facility	~ 85%

The above criterion is not met.

2011 Service Area Rehabilitation Bed Utilization

Facility	Rehab Beds	2010 Occupancy
Baptist Hospital	24	69.0%
Skyline Medical Center	41	75.5%
Vanderbilt Stallworth	80	77.6%
Southern Hills Medical Center	12	69.2%
McFarland Hospital	26	29.4%

Source: Joint Annual Report of Hospitals 2011, Division of Health Statistics, Tennessee Department of Health
**The 171 total beds represent only the operational beds as of the 2011 JAR. See note below*

Note to Agency Members: Nashville Rehabilitation Hospital's 31 beds are licensed "in abeyance" and have been nonoperational for several years. Skyline Madison's 10 licensed rehabilitation beds have been nonoperational.

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board certified physiatrist.

Staffing conforms to licensure requirements. Summit will seek a board-certified physiatrist as medical director of the rehabilitation unit. Physiatrists direct the rehabilitation programs at Skyline and Southern Hills.